JOURNAL

of the

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The Official Publication of the Podiatry-Chiropody Profession

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VOLUME 49, NUMBER 11

NOVEMBER, 1959

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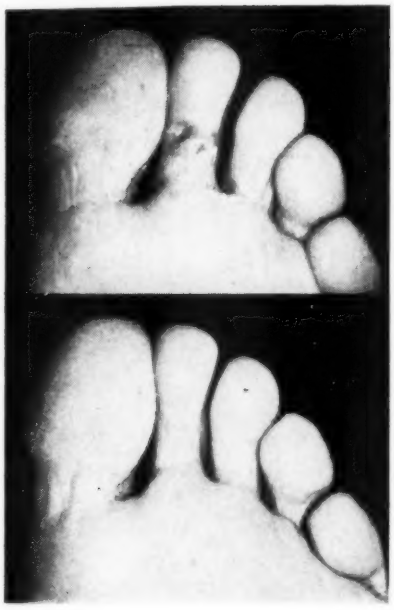

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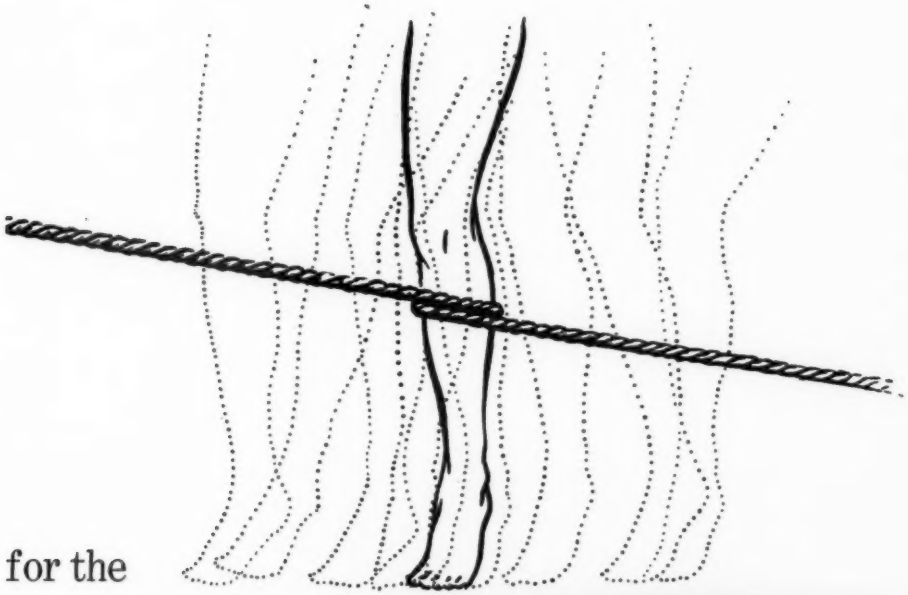

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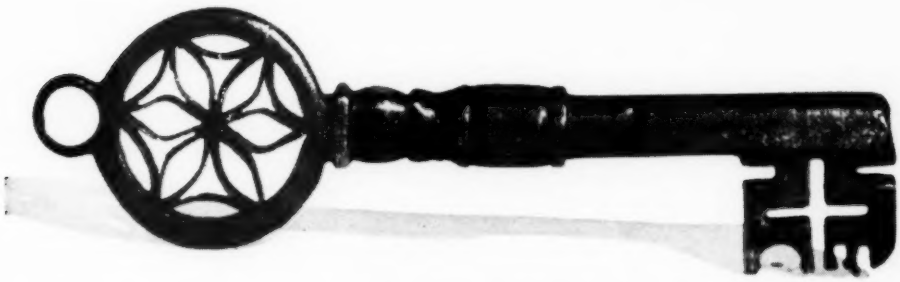

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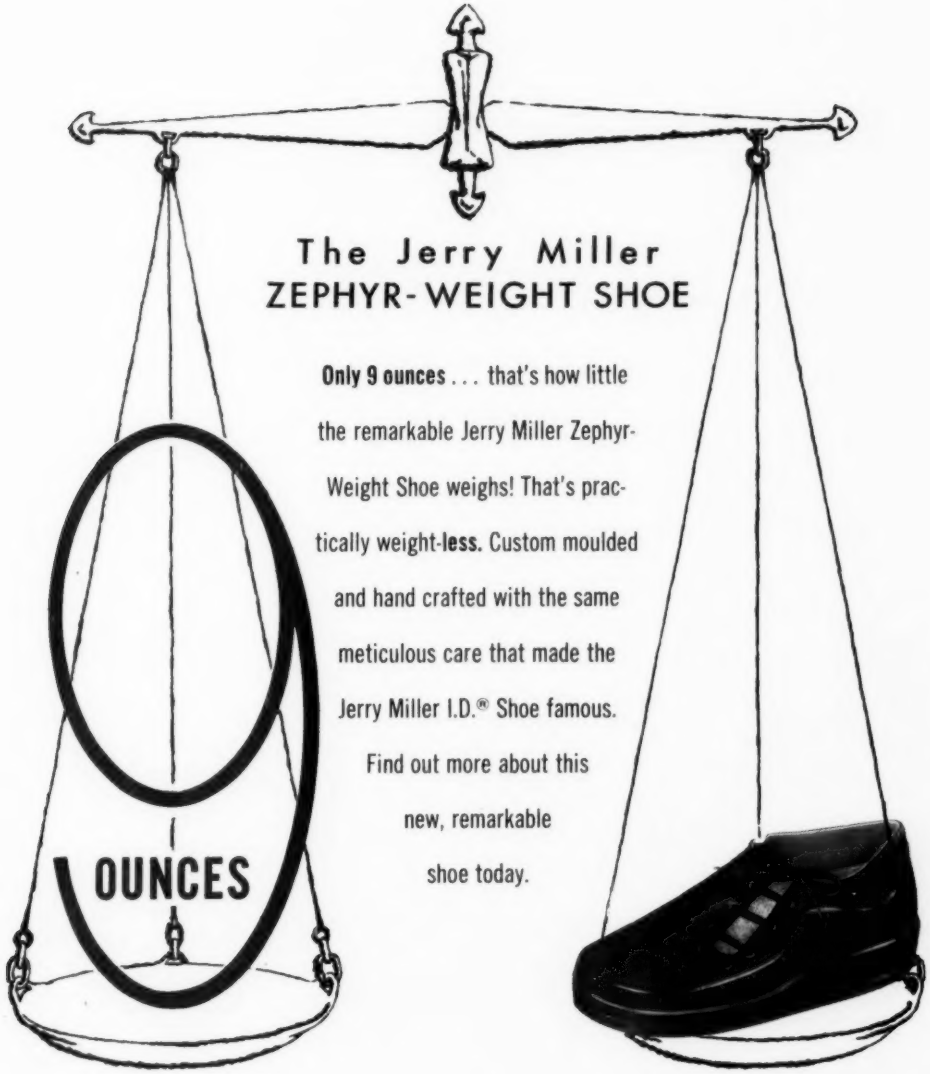

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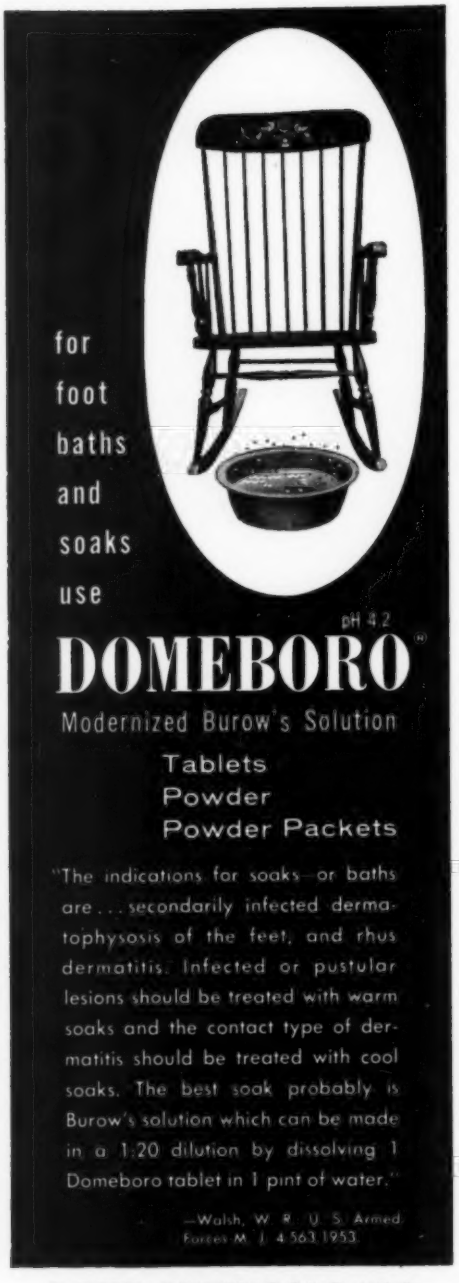
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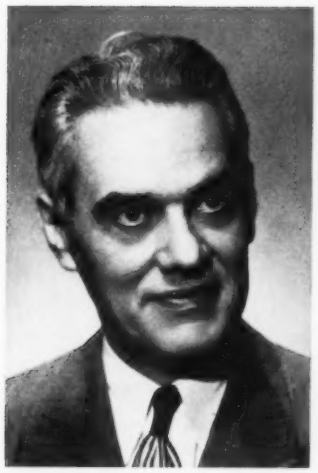

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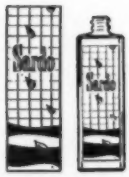

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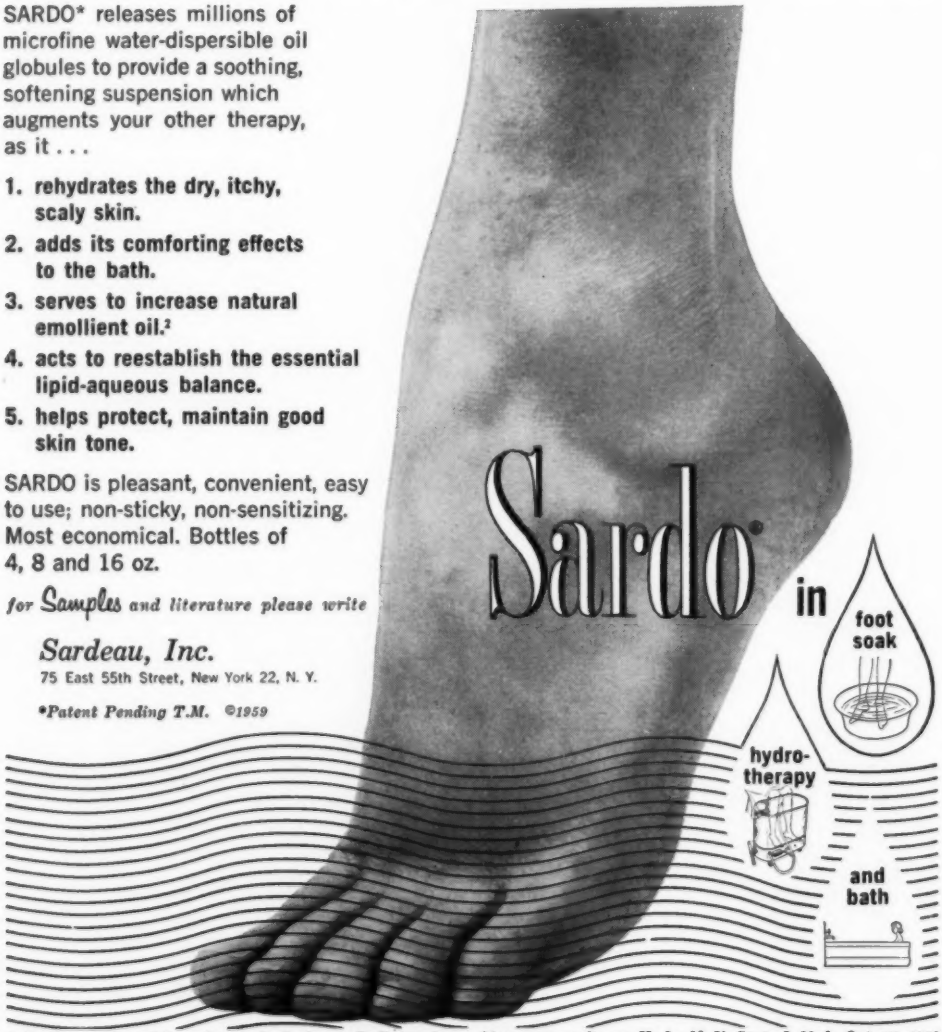

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JOURNAL

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THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

VOLUME 49 NOVEMBER, 1959 NUMBER 11

A COMPREHENSIVE PROGRAM OF PROPHYLAXIS FOR CONTROL OF DERMATOPHYTOSIS*

WALTER E. CARPENTER, D.S.C.
Porterville, California

A two year study at the Porterville State Hospital has demonstrated the effectiveness of the mass use of powder as a prophylactic for dermatophytosis of the feet. Because the conducting of foot and shoe surveys is necessarily an integral part of this over-all program, the survey procedure used will be dealt with in some detail. The findings reported herein are the results of studies conducted at Porterville State Hospital during the years of 1956 and 1957. Porterville State Hospital is a hospital for the mentally retarded, located in central California and has a population of 2,500 patients, ranging in age from 2 to 80 years.

The survey team was composed of the podiatrist, his assistant, and two psychiatric technicians from the ward being surveyed. The duties of the various members of this team will be explained as the actual survey procedure is related. A long range survey schedule is made up for at least six months in advance, and in order to disrupt the normal ward schedule as little as possible, the following has been made part of the regular routine:

1. Each ward is called several days in advance to make sure that no other activity is scheduled which might interfere with the survey. A date which is satisfactory to both the podiatrist and the ward nursing staff is then agreed upon.
2. Usually two or three days in advance the survey sheets (Fig. 1) with the headings typed in, are sent to the ward with the following instructions attached:
   a) List all patients alphabetically.
   b) Note patients not on the ward (use d/1 for definite leave, etc.).
   c) Make one carbon copy. Retain both copies on the ward.
   d) We will be on the ward on the above date at 8:30 a.m.
   e) Please provide one small table, two chairs, and a foot measuring stick.
   f) We will arrange to take those patients with school and industrial therapy assignments first.
   g) We will need someone to work with us who can identify the patients and is familiar with the patient's shoe problems.

*Paper submitted to and approved by Dr. James T. Shelton, Superintendent and Medical Director of Porterville State Hospital. The basic statistic results and procedure embodied herein were presented to the Eighth Annual Meeting of the California State Hospital Podiatrists at Mendocino State Hospital, October 7, 1958.

h) The survey will be conducted in the large room adjacent to the clothing room.

The walls of the room in which we conduct these surveys are equipped with benches. The actual examining area is established immediately adjacent to the door to the ward clothes room which is located at one end of the room in which the surveys are conducted. This provides easy access to each patient's shoes so that they can be checked at the same time the feet are checked.

Patients are escorted to this room, by a psychiatric technician, in groups of six or eight or up to as many as twenty, depending on their age, activeness, and behavior. They are seated around the room alphabetically, and are checked in that order, except for industrial therapy and school patients who, as it was previously stated, are examined first so that they may go to their assignments as nearly on schedule as possible. The patients are asked to remove their shoes and socks and carry this foot gear with them. The patients are checked for degree of imbalance and measured (both feet, standing), then they are seated and the width of both feet checked while at the same time observing any abnormalities which may be present. All these findings are "called out" to the podiatrist's assistant who records them in the proper column on the survey sheet. (Fig. 1).

At this point the shoes, which the psychiatric technician who is assigned to the clothing room has previously set out, as well as the shoes the patient is wearing, are checked for size, condition and type. Shoes which it is felt for any reason may be a contributing factor to fungus growth are eliminated at this time, except in those cases where such foot gear may be necessary to cope with some other deficiency. If they have been outgrown, or worn out, such information is recorded on the survey sheet and the "Req" (indicating "Requisition") column is checked. This makes ordering shoes easier for the psychiatric technician or nurse in charge of the award, as the shoe size, as well as the needs of the individual patients, are both indicated on the survey sheet. If the shoes are completely adequate, this too is noted. A list of those patients who need shoes and have funds in their personal accounts, or those whose parents have requested information regarding clothing needs, is made and the appropriate recommendations referred to the Social Service Division or Volunteer Service Section of the hospital.

A number of symbols have been developed which convey information in the briefest possible form to all who review these survey sheets. For example, a condition which needs immediate treatment is so indicated by a double star (**) in the Rx (treatment) column. Those patients who are to be placed on the future treatment list are designated with a single star (*). The degree of imbalance is designated with a 1, 2, 3 or 4 in the "physical findings" column. Heloma (HD or HM), plantar warts (PW), and similar conditions are recorded in the "physical findings" column, along with their location so as to facilitate later treatment.

The survey of the individual having been completed, the patient is asked to redress his feet and return to the ward day hall or to his assignment, if any. The examination of the next patient is then begun. The patients are kept, as nearly as possible, constantly moving into, around, then out of the examining room. This whole procedure requires from 2½ to 3½ hours for the average ward with a population of approximately 70 patients.

In addition to the services outlined above, we have recently expanded the scope of our surveys to include the tagging of shoes to be sent to the shoe shop either for repair or to be condemned. The podiatrist's assistant writes these tags and at-

Ward M-16 7-7-57

FOOT AND SHOE SURVEY

Name Case# #pr. Leather #pr. Cloth Usable Med. Findings Rx Req Size

Fig. 1. Heading of Survey Sheets.

taches them to the shoes, thus facilitating the handling of these shoes by the ward personnel and the shoe repairman. Tags directing the shoemaker to apply corrective wedgings and lifts are written later by the podiatrist's assistant, according to the directions of the podiatrist, and delivered to the wards by the nursing area supervisors.

These surveys are conducted on the wards at varying intervals, depending on the type of patients housed on a particular ward. As an example, our schedule may call for yearly surveys of wards upon which patients are confined to bed or wheel chairs while active, growing, "school type" patients are seen at more frequent intervals.

M-16, the ward upon which our initial survey was conducted, houses approximately 70 active, mildly retarded boys, ranging from 12 to 17 years of age. The survey sheet now being used is the result of many revisions made to simplify the form, while providing the greatest possible amount of information on a single sheet. (See Fig. 1).

The resume figures compiled following the routine survey of Ward M-16 on July 17, 1956, revealed that of 71 patients on the ward there were 30 cases of epidermophytosis. This includes all types of fungus infections of the skin of the feet. These cases were not confined by laboratory cultures, but based on clinical findings. Fungus infections of the skin are prevalent in a hospital setting such as Porterville, due in part to the close contact necessitated by so many living in close proximity. The number of fungus infections of the feet found on M-16 represented 42.2% of the total number of patients on the ward; thus it was felt that means should be taken to develop prophylactic measures to prevent such an occurrence the following year.

Many of the boys on Ward M-16 were enrolled in the hospital's school program. Physical activity, with its subsequent excess perspiration, foot gear, and bathing habits, were all considered in trying to evolve a workable prophylactic program. The changes in the hormone makeup of the skin due to sex and age received consideration because our own experience has shown that more males than females have fungus skin infections of the feet and that above the age of puberty the incidence rises markedly, presumably because of hormone changes in the skin. We consulted with ward physicians, ward nursing personnel, the pharmacist, and nursing area supervisors regarding this situation.

The consensus of opinion was that from the standpoint of ease of application, cost and potential effectiveness, the most feasible approach to the problem would be a program of mass powdering of the patients' shoes. It did not seem feasible to powder each patient's feet each morning, as the time between arising and breakfast is allotted to the various tasks which are necessary in preparation for the day ahead. To add the confusion of trying to powder each patient's feet every morning before he dresses might, it was felt, disrupt an already full schedule. Thus, it seemed logical to develop a routine for powdering each patient's shoes every night after he retired and when more time existed for this effort.

Tests were made using covered tables placed in the day halls. Those patients

capable of doing so placed their shoes on these tables as they retired. Ward personnel placed the shoes on the tables for those patients who were unable to do this for themselves. The actual powdering of the shoes was done later in the evening by a psychiatric technician. It was found by experience that this procedure required only about 30 minutes and that the average amount of powder used per day per ward (70 to 80 patients) was one 3½ ounce can. This plan was well worked out with personnel concerned in advance of the time it was to be put into effect.

It was decided that since we had an ample supply of "G.I." foot powder which had proven very effective for standard therapeutic use, we would use this powder for our mass powdering prophylactic tests. The original findings of this program have been verified during the time since this test by hospital-wide use of foot powder. The prime difference being that since the "type" foot powder used in the original tests is no longer available, bulk powder is now being used. The formula for this "G.I." foot powder was obtained from the Army Medical Corps by our Pharmacist and put out for bid through our Business Service Division. A bulk price in two and four hundred pound lots of powder was obtained. The formula for this powder is as follows:

Salicylic Acid USP	2%
Boric Acid USP	6%
Zinc Stearate USP	3%
Exsiccated Alum USP	1%
Starch USP	10%
Powdered Talcum	78%

Our Pharmacist handles this powder and packages it in six-pound bags. It is dispensed to the individual wards in these amounts since experience has shown this to be about a month's supply for the average ward. Shaker top cans were saved in anticipation of the use of bulk powder and a reserve supply of these cans is being held in the podiatrist's office as replacements for any that may become damaged on the ward.

The summers in this central California area, in which Porterville is located, start early. Temperatures in excess of 90 degrees are not uncommon in the month of May, nor are temperatures of 110 or 112 degrees in the months of June, July, August or September. In order to have a plan of mass powdering in operation and running smoothly before the onset of warm weather, the personnel on the test ward were asked to inaugurate the program on April 15. The shoes of all patients concerned were to be powdered nightly until such time as the order was rescinded by the podiatrist. It was planned that another survey for comparison purposes would be conducted at approximately the same date in July that the survey had been carried out the previous year so as to get as nearly as possible an exact parallel with the two surveys.

On July 9, 1957, the test ward was resurveyed with the prime object of obtaining, as nearly as possible, an exact picture of the condition of the patients' feet in relation to fungus skin infections for comparison with the figures obtained during the 1956 survey.

After completing the 1957 foot survey on the test ward, compilation of statistics revealed only two cases of athlete's foot, or 3.0% as compared to 39.2% from the previous survey.

Our initial reaction was one of pleasure; but pleasure with reservation when we realized that a number of patients had been transferred off the ward and replaced by other patients who had not been surveyed previously. The possibility of a hormonal factor was also considered, but was discounted when it was found that in spite of an appreciable number of transfers, the change of the average age of the patients was not significant.

As a means of checking our results still further, we again went over our findings,

considering only those patients who had been on the ward through both surveys. We found that a total of 30 boys had been surveyed in both 1956 and 1957. Of this group 13 were clinically diagnosed as having dermatophytosis during the 1956 survey. A survey of the same group in 1957 revealed only one such case. In other words, of this group 43.3% had fungus skin infections in 1956 and only 3.3% in 1957. Since all circumstances were kept as nearly constant as possible except for the daily use of powder, it was felt that this was the factor which had brought about the improved condition.

It may be possible that since the powder was used in the shoes instead of on the feet that a dual effect was obtained. First, it had a drying and disinfecting action on the shoes during the night with the result that the shoes may have been less apt to produce reinfection. Secondly, the direct effect of powder on the skin was also obtained as the powder filtered through the socks after the shoes were put on. The drying effect of powder upon the skin (especially the interspaces) makes for a healthier integument which is more resistant to the fungi.

Some of our patients have a more or less perennial problem with excessive perspiration due perhaps in part to the fact that our wards have radiantly heated floors. Certain of these patients derive benefit from the use of powder even during the time of the year when it is cool outside. In view of this, we have found it advantageous to continue this program on a curtailed basis during the winter months. It has been found that consumption of powder during this period can be cut to approximately one-third the summer rate and still take care of all patients' needs in this category.

Summary

The decided (93%) drop in the number of cases of athlete's foot as noted in the Ward M-16 test has resulted in:

a) A drop in the amount of discomfort experienced by our patients.
b) A drop in the secondary infections due to scratching from pruritus.
c) A drop in the use of other treatment medications, thus the costs of the powder (just under 8 cents per day per ward) is more than compensated for.
d) A savings of personnel time due to the decrease in the number of foot treatments necessitating their attention.

P. O. Box 2000

"Slow me down, Lord, and inspire me to send my roots deep into the soil of life's enduring values, that I may grow toward the stars of my great destiny. Amen."

Unknown

RADIATION SAFETY IN PODIATRY

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Doctor, Do You Use X-Ray as a Diagnostic Aid in Your Practice?

THIS question is being answered affirmatively by an increasing number of practitioners in every branch of the healing arts, including podiatry.

We in podiatry who use the x-ray machine realize that it is an invaluable tool in diagnosis, and many podiatrists have achieved a high degree of skill in roentgenographic techniques and film interpretation. However, this is not sufficient.

Podiatrists must be prepared to answer questions about x-ray safety and radiation protection, because in recent years the public has become acutely aware of radiation. The very word "radiation" seems to instill fear and awe in the minds of many. Press and magazine articles pointing up the hazards of radiation due to the use of x-rays and fall-out from bomb testing, have become an everyday occurrence. Some of these articles have served to heighten the ever-mounting confusion which already exists in the public mind concerning radiation, and every branch of the medical profession has been confronted with increasing resistance on the part of the general public to the use of x-ray.

Podiatrists must equip themselves with the knowledge necessary to dispel unfounded fears concerning radiation. To do this effectively, we must be aware of the latest recommendations for x-ray protection and safety made by the National Committee on Radiation Protection and Measurements, and we must make sure that our x-ray installations are operated in accordance with these recommendations.

As a member of the Radiological Health Unit of the New York City Department of Health, I have had the opportunity to take part in the program of radiation control which was in effect for several years. My interest in radiation stemmed originally from the use of the shoe-fitting fluoroscopy machine in the shoe stores in New York City which the Department of Health had under permit and regulation.

Recently the City expanded its radiation control program, and a new office was created, known as the Office of Radiation Control, to which I am now assigned. This office is directed by a renowned radiation physicist, who is aided by a technically trained staff, equipped to do radiation inspection work. The function of this group is the control of all types of radiation hazards in the City of New York, but the major problem here is considered to be the dental and medical uses of x-ray.

The first step in this control program was the registration of all sources of radiation in the City of New York, such as x-ray machines and/or radioactive isotopes in medical, dental, podiatric, osteopathic and veterinary offices; in hospitals, clinics, private and commercial laboratories, in universities and industrial plants and laboratories, etc. Those of you who practice in New York City are familiar with the registration form, since you were all required to register your x-ray machines.

The registration form includes a questionnaire which asks information about the type of installation, the age of equipment, size of rooms, occupancy of surrounding space, shielding in walls and floors, and other pertinent data. All this information is coded and then keypunched on I.B.M. cards. The inspection program is based on an analysis of the information on the registration forms. Those installations which seem to be hazardous from the standpoint of age of equipment, improper or inadequate shielding, lack of

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proper cones or diaphragms to limit the x-ray beam to the area of clinical interest, etc., will be given priority in inspection. More than 12,000 installations have been registered since the beginning of the program on October 1, 1958. It can be realized that the job to be done in radiation control in New York City is an undertaking of very large proportions, and one which we in the Office of Radiation Control consider very important.

Since in podiatry we are concerned with x-rays mainly, no attempt will be made to discuss the physics of nuclear radiation in this paper. This article will be limited to the problems attendant to the use of x-rays in podiatry.

X-rays were discovered in 1895 by Roentgen, who found that they were electromagnetic radiation, like light or radio waves and that they were highly penetrating and would blacken photographic film or light a fluorescent screen. The x-ray tube of today, although considerably improved and modernized since the days of Roentgen, is essentially the same basically. X-rays are generated by allowing a beam of electrons to strike a metal target in a vacuum tube. The resultant rays, X-rays as we know them, have been put to many wonderful uses.

The original acceleration of the x-ray beam is achieved by placing a high voltage between the electron (cathode) and the target (anode). The x-ray tube voltage usually measured in kilovolts (kv) and the cathode-to-anode electron flow, usually measured in milliamperes (ma), together determine the intensity of the x-ray output. The higher the kv, the greater the *speed* of the electrons striking the target and the more penetrating the x-rays generated. The higher the cathode-anode current (milliampere setting 'ma'), the greater the *number* of electrons striking the target, and accordingly the greater the *quantity* of x-rays of the given penetrating power generated.

It is well known that radiation can be highly dangerous, but it is not wise and certainly impractical to recommend that *all* use of radiation be banned or even that all exposure of people to radiation be prevented. However, it is our purpose to eliminate all radiation not serving a useful purpose, and representing a hazard. To this end we have banned the use of all shoe-fitting fluoroscopy machines in New York City, as of February 15, 1958. Since it is impossible and undesirable to impede progress, large sources of radiation are bound to be used in industry and power production, quite apart from medicine.

There are three dangerous biological effects of radiation to man. There is the immediate danger of damage or destruction of tissue from individual high exposure; there are long-term dangers of chronic damage to tissue with possible induction of cancer; and there is the remote but important danger of permanent genetic damage that may seriously affect future generations.

We must also consider that our patient is exposed to radiation from various sources, such as radiation resulting from the presence of natural radioactive substances in the environment (radium and radioactive potassium and thorium, for example) as well as contributions from cosmic radiation and fall-out from bomb testing. In addition, there is radiation related to the peaceful uses of atomic energy in industry, and this radiation may be expected to increase as a hazard with the increased use of atomic energy in industry.

As podiatrists, we must also take into consideration the radiation exposure to our patient from other procedures encountered in the many routine examinations in the dental and medical office. It behooves *us, then,* to make sure that any exposure to radiation should be reduced to the lowest level consistent with good diagnosis or therapy.

Experience in radiation therapy has shown that there is usually no permanent damage to most normal tissues after single exposure of less than 1000 roentgens to a *limited area*, and it is difficult to observe even any temporary damage at doses under 100 roentgens (the roentgen is that quantity of X or gamma radiation such that the associated corpuscular emission per 0.001293 grams of air (1 cc of air at standard conditions of temperature and pressure) produces in air, ions carrying 1 electrostatic unit of electricity of either sign). The reproductive and blood-forming organs are the important exceptions; 50 roentgens can cause temporary sterility and 25 roentgens can cause temporary changes in white blood cells. If these low doses are repeated daily, weekly, or even yearly, they are far above the levels that can cause long-term and remote injuries.

Excluding remote genetic hazards, long-term effects have been seen in human beings exposed to radiation. Early x-ray workers, medical radiologists mainly, but some other workers too, especially those who worked in the manufacture, development, and testing of x-ray tubes did not know the danger of constant exposure, even at apparently low levels. It used to be common practice, for instance, for the radiologist to place his own hand in the x-ray beam to see whether the tube was working properly (early tubes were very unreliable). Early x-ray machines were not well shielded in any case, and it was difficult for the operator not to receive some radiation even during normal operations, especially on his hands.

The earliest changes seen in the fingers were brittleness and ridging of the nails, and blunting and flattening of the skin ridges that show in fingerprints. I have personally observed these changes on the fingers of dentists who had held films in the patients' mouths during radiography. The skin also shows dryness, loss of hair, loss of sensitiveness and liability to chapping.

After many years these typical changes may lead to the development of skin cancer in some cases. Leukemia has also appeared more commonly in workers exposed to radiation from x-rays than in the general population. A recent survey in the United States showed that leukemia was about 10 times as common in radiologists as in other doctors.

Mention must be made of genetic danger, considered to be the most serious, since it occurs even at the lowest levels of radiation, and is the most difficult to evaluate. Changes in genes, known as mutations, occur spontaneously at a constant low rate (about one mutation per million genes per nuclear division). Ionizing radiation causes both *major* changes in chromosomes, usually resulting in death for the cell, and *minor* changes which appear as gene mutations. Radiation-induced mutations are mostly both deleterious and recessive. None of these mutations are, therefore, capable of being detected until eventually an individual is born, both of whose parents carry the same recessive mutant gene.

It is certain that these mutations occur, and it is also certain that they are cumulative with no threshold below which none occur. All radiation, at whatever level, that an individual receives during his whole life up to the time at which children are conceived must be added together and will possibly cause genetic changes. There is no disagreement over these statements, but there is considerable doubt about the quantitative assessment of the danger.

The National Committee on Radiation and Measurement recommends that the maximum permissible dose to the gonads for the population of the U. S. as a whole from all sources of radiation, including medical and other man-made sources, and background, shall not exceed 14 million rems per million of population over the

period from conception up to age 30, and one-third that amount in each decade thereafter. (The rem is the quantity of any ionizing radiation such that the energy imparted to any biological system (cell, tissue, organ or organism) per gram of living matter by the ionizing particles present in the region of interest, has the same biological effectiveness as an absorbed dose of 1 rad of X-radiation, with average specific ionization of 100 ion pairs per micron of water in the same region. For lightly filtered 200 kv x-rays 1 rem = 1 rad. The rad is the unit of absorbed dose and is equal to 100 ergs per gram of tissue.)

At this time it might be wise to define a permissible dose of ionizing radiation. This definition is for persons who are occupationally exposed to radiation. The permissible dose is a dose of ionizing radiation accumulated of such magnitude that in the light of present knowledge, exposure at this rate for an indefinite period of time is not expected to cause appreciable bodily injury to a person at any time during his lifetime.

For persons occupationally exposed to external radiation, "the maximum permissible dose (MPD) to the most critical organs (whole body, head and trunk, active-blood-forming organs, or gonads) accumulated at any age shall not exceed 5 rems multiplied by the number of years beyond 18, and the dose in any 13 consecutive weeks shall not exceed 3 rems." "Thus, the accumulated MPD = (N-18) x 5 rems, where N is the age in years and is greater than 18."

The concept of maximum permissible dose is more complicated actually than was just stated, but for our purposes I believe it will suffice. It should be noted that these recommendations for radiation safety which are promulgated by the National Committee on Radiation Protection and Measurements are continually under surveillance, and should new information appear which indicates that more stringent requirements are in order, this will be studied by the Committee.

To get down specifically to our findings concerning the use of x-ray in podiatry, a survey was undertaken by the New York City Radiological Health Unit during the latter part of 1957 and early 1958. In this survey more than 50 podiatry offices using x-rays were visited. The survey included observation of the techniques used to make the x-ray exposure, the position of the operator in relation to the x-ray machine and patient, a measurement of the diameter of the primary beam of the x-ray (The primary beam diameter is the diameter of the circle which is actually struck by x-rays emerging from the x-ray portal), a measurement of the dose delivered to the patient during exposure, a measurement of radiation intensity levels from scatter radiation at the various operator positions, as well as a physical inspection of the x-ray machine for aluminum filtration and beam limiting devices, such as lead diaphragms or other cones or collimating devices.

Radiation dose rate levels were also measured in waiting rooms and other adjacent space. A wide variety of x-ray machines were seen in this survey, including Ritter, XRM, Profex-ray, Waite & Bartlett, McFedries, Wappler, Universal, Weber, Victor, Mattern and several nameless and nondescript among which were several nonshockproof.

I will try to present a summary of our findings and then make some recommendations. In most instances it was found that the x-ray machines were operated without any added aluminum filtration. X-ray tubes have an inherent filtration in most cases equivalent to one-half millimeter of aluminum. For mobile units, National Bureau of Standards Handbook No. 60 recommends that the total filter permanently in the useful beam be equal to at least 1½ mm. of aluminum. This means 1 mm. added aluminum.

Let me explain the function of the aluminum filter. X-rays which are generated at any given kilovoltage peak are not of a single energy level, i.e., the beam is not a mono-energetic beam of one constant energy. For instance, if your machine is set at 65 KVP, the emergent beams are made up of a spectrum of energies which may vary from 50 KVP to 65 KVP—65 KVP represents the kilovoltage peak. The x-rays produced by the higher kilovoltage are of the shorter wavelength, more energetic and more penetrant type than those produced by the lower kilovoltage. These shorter wavelength, higher energy beams are therefore the ones which penetrate the tissues and bones of the foot, giving us the desired radiograph. The lower energy rays are absorbed by the skin surface and do not help to make the radiograph, but do add to the radiation exposure of both patient and operator. It is desirable, therefore, to filter these low energy x-rays out, and this can be accomplished by the addition of an aluminum filter. At 65 KVP, the addition of 1 mm. of aluminum has been shown to reduce the primary beam dose by as much as 35 percent.

Our survey also indicated that very few machines were equipped with lead diaphragms or cones or other useful beam limiting devices to restrict the radiographic field to one not larger than clinically necessary. For instance, we found that in most cases the x-ray machine was operated so that the target-to-film distance was 30 inches, and in some cases 24 inches or 20 inches. At these distances, the resultant useful beam diameters were measured by darkening the room and allowing the x-rays to fall upon a specially made ruler, made up of fluorescent screen material put together like a carpenter's ruler and marked off in inches. In this way, the diameter of the beam was read directly when the x-rays were focused on this ruler. Many beam diameters exceeded 24 inches, some being as much as 26 inches. This excessive x-ray beam diameter is both unnecessary and hazardous, since the scattered radiation from this large area encompasses a much greater portion of the room than that from a smaller area. For podiatry practice, we feel that it is unnecessary to have the useful x-ray beam diameter any greater than 15 inches to 16 inches, since the largest x-ray film used most frequently is 10 inches by 12 inches, and for the average procedure, an 8 inch by 10 inch film will do very nicely.

Measurements of the x-ray beam dose were made using the Victoreen condenser roentgen meter chambers. Results varying from 0.2 roentgens per second of exposure to 0.4 roentgens per second of exposure were obtained, depending upon kv and ma settings. The most usual settings encountered were 55 kv, and 10 milliamperes. In some instances, four exposures of 2-3 seconds each were taken per patient. This means that the patient's feet were exposed to radiation varying from 0.8 roentgens to 4.8 roentgens.

Measurements of scattered radiation were taken using a hot water bottle filled with water as a phantom scattering device simulating the human foot; our measurements having previously indicated that the hot water bottle filled with water gives comparable results to scatter directly from a human foot.

Scatter radiation intensity levels were taken at positions simulating the patient's gonads, and at the operator's position. Readings varying from .05 milliroentgens per exposure to 2.5 milliroentgens per exposure were encountered at the gonad positions. This can be considered as important since geneticists feel that all radiation to the gonads is harmful for it increases the rate of mutation. Readings varying from .05 milliroentgens per exposure to 1.6 milliroentgens per exposure were found at the operator's position. In all instances, where

possible, a new position for the operator was recommended which considerably reduced the exposure to scattered radiation.

In some instances, radiation dose rate levels taken in waiting rooms reached 400 mr/hr. (equivalent to 0.33 milliroentgens per 3 second exposure). Let me state here and now that these readings in and of themselves are meaningless. They must be considered in relation to workload and occupancy factors. For instance, if you use your x-ray once a week for 4 seconds, and the scattered radiation at your position was even as high as 1000 milliroentgens per hour (1 roentgen), we have to remember that there are 3600 seconds in every hour, so that by simple calculation, we conclude that it would require ninety (90) four-second exposures before you would receive your maximum weekly permissible dose of 100 milliroentgens. However, if we can find a position where you can take the same radiograph and only receive 10 mr/hr. rather than 1000 milliroentgen/hr., then this is the position we would recommend for you. We work on the premise that all radiation is harmful, especially from the genetic standpoint, so we want to keep it at a minimum. If yours is a busy office and you take 40-50 radiographs per week, then you certainly want to be in the position of least radiation exposure. We must consider, too, the occupancy surrounding your x-ray room. If you have a receptionist, or assistant, and her desk is in a room adjacent to an x-ray room, make sure that the primary beam is not pointed in this direction during radiography, while she is sitting at the desk. If your assistant has been shown how to take radiographs, make sure that she stands at the full length of the timer cord, putting as much distance between the patient and herself as is possible. This admonition goes for you, too, since radiation intensity varies inversely as the square of the distance from the source, at 6 feet you are getting only one-ninth of the radiation you would get at 2 feet from the source.

Our survey also indicated several instances where the practitioner positioned the patient for x-ray, then remained standing right close to the patient's position while pressing the timer button. In one instance, the practitioner stated that he actually holds the cardboard film holder during radiography. These are certainly practices to be avoided.

In regard to film, most of us in podiatry use no-screen film for several reasons, chief among which is lower cost, and secondly because there is usually good soft tissue detail if the radiographic technique is good. However, our unit has been in touch with the various film companies, and we have had excellent cooperation from them regarding fast film and also screen film information. There are some no-screen films which allow us to reduce the radiation exposure by one-third and still give a good diagnostic film.

Another film company cooperated by doing some actual foot radiography using cassettes containing intensifying screens. The use of these screens allows one to considerably reduce exposure time since the x-rays striking the intensifying screen causes it to give off rays which help produce the image on the film. It has been claimed that the use of intensifying screens produces films with poor soft tissue detail. However, the experimental films shown to our unit had very good soft tissue detail, as well as fine bone structure detail. Of course, podiatrists are not too overly concerned with soft tissue detail, but a good film shows both good soft tissue and good bone detail. These exposures were made using the usual podiatry kilovoltage and milliamperage settings, but at exposure times ranging from one-half to three-quarters of a second. This gives considerably less radiation to both patient and operator than the usual two to three second expo-

sures in current use. However, one must mention that the initial investment for cassettes and good intensifying screens is considerable, averaging around $35.00 or $40.00 for each cassette. Also, one must be much more careful and meticulous in developing techniques, for a few drops of developer or fixer can ruin a good screen in a very short time. Intensifying screens and cassettes are an avenue certainly worthwhile investigating in podiatry x-ray practice where a considerable amount of radiography is done.

It is our hope, when the program of the Office of Radiation Control gets rolling in high gear, to undertake research along the lines of getting good diagnostic films using minimum exposure times, fastest film possible, and other techniques to reduce radiation exposure to patients and operators. This research will not be specifically for podiatry, but is an all-encompassing program for radiography in general, and it will be under the direction of competent radiation physicists being recruited by the Office of Radiation Control.

Another avenue of research which will be explored will be a detailed investigation of the shielding value of commercial building materials, such as brick, plasterboard, cinder block, concrete block, wooden flooring, steel partitions, etc., as compared to lead. This is considered to be very important, since we are all concerned with preventing radiation from reaching our neighbors in the surrounding occupied space, including the people who may be living above or below our x-ray installation. The results of this research will, of course, be made available to all professions.

At this point I would like to briefly summarize the salient points which make for good radiation control and safety in our practice:

1. At least 1 millimeter of *added* aluminum filter mounted permanently in the path of the primary beam.
2. Lead diaphragm or other beam limiting (collimating) device to limit beam diameter to 15½"-16" maximum.
3. Fastest film possible to obtain, with consequent reduction in exposure time (milliampere seconds — MAS), and therefore less radiation exposure to patient and operator.
4. Highest kilovoltage (KV) possible without imposing strain or excessive load on your tube. High KV in combination with proper aluminum filtration, results in the production of more energetic, shorter wave length, deeply penetrating x-rays which contribute to your radiographic result, and this combination also eliminates the softer, low energy, less penetrating x-rays which only contribute to skin radiation exposure.
5. It has been suggested by competent authorities in this field that some shielding be applied to the gonadal area, particularly when working with children and young adults. This can be accomplished by the use of a piece of leaded rubber or lead rubber apron thrown over the patient's lap and lower abdomen during radiography.
6. During radiography, the operator should stand at the full length of the timer cord, and in a direction opposite to the path of the primary beam. This is usually the position of least scatter radiation to the operator. In busy practices, where the x-ray machine is used quite frequently and its location is such that it is inconvenient for the operator to stand at least six feet from the patient for all exposures, then the use of a portable (lead shielded) floor screen, with a leaded glass viewing port is recommended.
7. The use of the x-ray machine should be limited to those cases where the clinical indications are such that a radiograph is necessary to help establish a diagnosis.

8. If one wishes to know just how much radiation one is being subjected to, especially in practices doing a lot of radiography, there are film badge services available at reasonable prices, which report the amount of radiation exposure as indicated by the film, which is usually worn on the person. The Office of Radiation Control is also investigating the feasibility of conducting radiation surveys in x-ray installations using film badges. In this type of a survey film badges would be placed all around an office, and in strategic spots in the surrounding occupied space, such as waiting rooms, etc. These would be left in place for a period of a month, then would be collected, developed, and examined for radiation exposure.

A film badge is a piece of radiation sensitive film in a suitable holder, usually equipped to index alpha, beta, as well as gamma and X-radiation. These films are worn, or otherwise exposed and then developed and compared to known exposure control films on a sensitive device known as a film densitometer. The comparison of the density of the film worn by the operator, or from locations around an installation, with the known control indicates the total accumulated radiation exposure for the time interval worn.

Another device for personnel monitoring is known as a pocket dosimeter. This device enables one to read the amount of radiation exposure immediately upon being exposed. However, pocket dosimeters are more expensive than film badges, and also require a charging mechanism.

Handbook 60, of the National Bureau of Standards "X-Ray Protection," Section 3.5 (a) states that "Personnel monitoring *shall* be required for each individual for whom there is any reasonable possibility of receiving a weekly dose of X-rays exceeding one-fourth the maximum permissible dose."

It is not likely that the weekly permissible dose would be exceeded in the usual podiatry x-ray practice, since it has been shown that an operator of a mobile medical diagnostic x-ray unit standing at least six feet from the tube and patient can make approximately 250 milliampere minutes of exposures in one week. This would correspond approximately to the weekly permissible dose.

In conclusion, may I say that the New York City Health Code section on the "Control of Radiological Hazards" requires that the recommendations found in Handbook No. 60 be followed, and these can be very easily and inexpensively put into practice in podiatry.

Many thanks to my associate, Ira R. Paul, and to the members of the Radiation Inspection Division for their invaluable aid in the actual field surveys in Podiatry Offices—and to Professor Hanson Blatz, Director of the Office of Radiation Control, for his valuable suggestions for the preparation of this paper.

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"A cynic has no influence and a pessimist no friends."

Raymond Moley in Newsweek

PODIATRY RESEARCH

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"Baffled Curiosity," "Creative Thought," "Creative Observation" are terms often mentioned in the current literature that are concerned with the research method. Science is a collective term for those who look inside our surroundings in the quest to control our surroundings. The arts, philosophy, theology, seek more to explain our surroundings or depict them. In all of this seeking to understand and control our surroundings, it is the mind of man using his mental faculties that attacks the problems confronting him. From cave paintings 17,000 years ago to our contemporary[1] atomic fission and fusion, the creative ideas of man have moved us from the prehistoric man to our present highly complicated, technological age. Research is the term used to denote the investigation pursued to secure new facts.

In seeking to establish a research program in the podiatry profession, there are two main factors involved: 1. The people who will do the research and 2. To provide the time, place, atmosphere and funds to pursue research. We have a few of these people. These are the highly motivated persons in whom burns the spark of curiosity, imagination and courage to delve into the unknown frontiers of foot problems.

In endeavoring to set up such a program, let us not delude ourselves that we can plan the results of such a program. How can one plan the unknown? We can provide the time, place and funds; we cannot provide the ideas . . . these come from human minds. We take a calculated risk and hope that some results will be forthcoming. This is not as discouraging as it may appear, as there is so much to learn about the human foot, that a program directed towards securing new facts in foot problems will undoubtedly bear fruit.

The people who do research and creative thinking in this world are unusual and rare people. They are very disturbing to people who want to proceed along the conventional and accepted lines of thinking. One whose concern, energies and thoughts are directed towards solving problems, investigating, thinking, creating, finds himself set off a bit as he goes his way. Neff[2] calls them "the heretics, the people who are independent, do their own thinking, they stand out, they are different and bring into the world the new ideas that upset conformists and neutralists. From Socrates and Jesus to Dewey and Einstein, the thinker has been the non-conformist, the critic, the rebel from established norms, and the desecrator of comfortable habits."

One of the first essentials then, in a thinking person, is to be curious. One who wants to find out "why this?," "why that?" Scientists and research people are looking for the facts that give the answers to the "why." In podiatry we wish to find some of these people who want the "whys" of foot problems, and then provide the facilities for them in their quest. Not everyone is motivated to do research and creative thinking because they do not have the curiosity essential to this type of endeavor. Most of us are interested in making a living, securing the comforts of life for ourselves and our family, and enjoying the contacts with other people. Creative thinkers like to do these things too, but they become somewhat secondary; their curiosity motivates them into interests beyond everyday living.

We are trained as professional people to treat patients and relieve human suffer-

†Chairman, A.P.A. Committee on Research

ing. This is our job and for what we were trained. As one develops technical skill and the ability to handle people, one becomes quite busy; there is no longer time to ask "why," and this has to be left to someone else who is interested in what we generally call research. Research and creative thinking demand additional training and educational background not essential to being a practitioner. These additional attributes can be learned by anyone who is interested.

Scientific investigation uses and develops methods that can be duplicated by another with the required interest, experience and training. Duplication verifies and validates facts another has presented. Theories and hypotheses may take years to prove as other developments make proof possible. Some theories and hypotheses are faulty and are later so proven. It is the adding of new ideas and material that is important; whether they have an immediate application may depend upon other facts elicited in the future.

There is no one accepted method of creative thinking or research, but the general method of problem solving, usually resolves itself into a process with the following arbitrary steps: The various aspects of the situation, the problems in each aspect, the specific problem, the plan of attack on the specific problem, attack of the problem, finding, conclusion, solution, hypothesis, etc.

Most problems have no final solution, for with further investigation, one finds more and more things that need investigating. This is when you become an authority. You know that many more particular aspects of the situation need investigating, and will continually find more.

Medical research usually starts with someone seeking an answer to a question. The first recourse is to search the literature on the subject, and not having found the answer there, make a plan to attack the problem.

Most medical problems have to be attacked piecemeal, like all biological problems, because they have so many interrelated aspects. For example, let's take a problem that I intend to look into some day, and attempt to make a plan to attack the problem.

The observation: Hallux valgus seems to occur most frequently, or almost entirely in the planate type of foot. Why? The literature has very little to say on this. Merton Root has suggested parts of an answer.

Plan of investigation: Clinically classify and examine 100 cases each of planate feet, normal appearing feet, and cavate feet, including Harris and Beath prints of each case, and standard x-rays. Evaluate on the basis of the three main classifications and the Root classification. Catalogue and summarize findings and what do you have? Can conclusions be drawn? Who knows until you do it?

General Remarks on Material And Background

One of the most valuable books for anyone interested in feet is *"Structure and Function as Seen in the Foot"* by Wood Jones. This book is a sleeper. If you think you know anatomy, wait until you read this. The comparative work and the anthropology presented is excellent.

A working knowledge of statistics is very important to any research worker. There are many excellent texts on this, some dealing especially with medical statistical applications. Inexpensive "paper backs" are available in stationery and book stores.

A mathematical background is also quite helpful, particularly if one gets into biomechanical work. Analytical geometry and calculus are usually involved. Photography and drawing are also big aids. It is surprising what practice does in these things. If you want to draw straight lines you use a ruler. Books on comparative anatomy like Romer's *"The Vertebrate Body"* and

the "*Anatomy of Domestic Animals*" by Sisson and Grossman are also helpful, as is "*Comparative Vertebrate Anatomy*" by Hyman. Human anatomy material usually can be used or obtained from the various medical schools and other colleges and universities. Several houses* can supply you with all types of comparative anatomical material as well as some human material. Your local butcher shop or slaughterhouse can supply you with extremities of cows, sheep and pigs. If you have a zoo in your town, they may be glad to supply you with deceased animal material. Many museums have collections of osteological material which they will allow you to use.

You must read, read, read. Read in the humanities, philosophy, theology, the various sciences. Follow the dictum, "read, weigh and consider." See how others in the past amongst the great creative minds of this world have developed their ideas. This is background for your own thinking. In the arts, develop an appreciation on how the artist or the composer or the novelist develops his ideas. You will soon learn the good from the bad, the superficial from the deep. Keep notes on everything and finally you will need to write. Writing takes practice and you will write and rewrite.

What problems among the many maladies of the human foot should we work on? What are the most important? There are no trite answers to such questions. It is very difficult to restrain ourselves from not setting out on the obvious; clinical appearances are only the outward signs of more involved manifestations. It is obviously foolish to treat or evaluate purely in the light of symptoms; the basis of our research must be on a premise of critical discernment and the "why" of things. How far this constant asking of why can take one, will soon be apparent in the problems listed.

*One such is Wards Natural Science Establishment, Inc., P.O. Box 24, Beechwood Station, Rochester 9, N.Y.

It is encouraging to note that the terms "flatfoot," "cavus," etc., have come into disrepute amongst the professions; I say encouraging because it denotes that creative thinking is prevalent on foot pathology. We realize now that to call a clinical condition a pathological condition is very naive. One might as well judge the function of the nose by its shape, or the eye by its color. What went by the name of "heart trouble," until recently covered a host f pathological conditions. We speak now of definite lesions, and will, in time, refine our concepts even more. We have in our profession evolved terms that get away from this generic thinking by the use of such terms as "lateral imbalance," "medial imbalance," "segmental imbalance," "forefoot imbalance," etc. I think now in terms of sub-astragalar functions in relation to so-called "arch trouble"; ten years from now it may be in different terms.

Chiropody research can range over a wide field of the sciences, but its primary domain seems to be in the field of what is now called bio-mechanics. This is an all-inclusive term that includes anthropology, anatomy, physiology, neurology, mechanics and comparative morphology, to mention a few.

Research in the medical fields can be divided into three main types of endeavor or lines of thought, but they are all so inter-related that the divisions must be regarded as purely arbitrary. These are (1) basic, (2) clinical, (3) applied. Basic research is usually of a type that investigates a subject without any particular use in mind for the facts obtained or deduced, but adds to human knowledge. Clinical research usually implies diagnosis and various types of treatment. It is the starting point for medical research as here are "picked up" the conditions that start one investigating causes, the why of things. Applied research is usually the application of materials, or basic facts to treatment, or

medications. Surgery is the application of all three plus the development of special techniques and dexterity. Chiropody functions in all fields. Our big need is in the basic fields.

Suggested Problems for Research In Podiatry

It is to me very difficult knowing where to stop in enumerating the possible lines of investigation; they are innumerable. I make no pretense then of this being a complete list, but my intent is to mention more the basic lines of possible investigation, for these lead into all phases of our work.

Yale[3] gives these:

1. There is the whole problem of the incidence of degenerative joint diseases of the foot as compared with other areas of the human body. So many of our patients who complain of minor foot disabilities are actually suffering from organic disease which is more general. We do know that many diseases show their first symptoms in the feet. We would all be advancing the cause of medicine if we had fundamental, imaginative research to fortify our theories in this field.

2. The cause, or etiology, of plantar warts and their relation to emotional stress is in its infancy.

3. We do not know enough about the pathology of the simple corn.

4. We have much research to do comment of hyperkeratosis, or thickening of the skin.

5. What about the incidence of calcification of the medial calcaneal branch of the posterior tibial artery in the age group cerning the role of Vitamin A in the treatof 20 through 40?

6. The relation of general bodily health to functional and structural disturbances of the feet.

7. What is the mechanism behind a local demineralization of bone at the site of inflammation?

8. Protein metabolism and its relationship to structural alterations in the human feet.

9. The histologic appearance of the periosteum enveloping the bones of the foot.

10. Is there a relationship between myocardial disease and connective tissue disturbances in feet?

Rubin[4] suggests the following:

A. Fundamental or basic sciences

1. Physiology and histopathology of the skin and its appendages.

a. Data on normal and pathological growth of nails.

Physiology and bio-chemistry of nails.

b. Changes in skin associated with senescence.

2. Bone and connective tissue studies

a. Bone growth and structure as related to stress.

b. Growth and development of bone during infancy, pre-school, early school, pubescence, adolescence, and early adult life.

c. Bone and connective tissue changes during the middle years and senescence.

3. Normal and pathological mechanics of stance and gait. This is a big field barely touched and, even in those areas where something has been done, much corroborative evidence is needed. I think this is the big area where our people can do the most.

B. Clinical sciences

The list here could be endless, and I am going to make only a few suggestions.

1. Footgear

We don't even know what the shoe industry has been doing, and I am sure that they must be doing something. What fundamental work have they done on lasts, manufacturing methods and materials? What statistical evidence can be produced showing the relationship between lasts, style and foot health prob-

lems? How effective are custom-molded shoes?

2. The same or similar questions can be asked with respect to arch supports, inlays, devices, shoe corrections, etc.

3. What information do we have on the pharmacy of drugs applied locally on the surface or by introduction into the tissues and joint spaces of the foot, especially the amount and extent of alteration of physiology and pathology?

4. In the systemic administration of drugs for a foot problem, are we fully cognizant of the effect on the foot, of the effect on the general systems affecting the foot, etc?

My suggested lines of investigation are as follows:

1. Pedotypes
   Establish means and variants.
   A problem in anthropological research.
   Material—Clinical photos, histories, roentgenographic studies.
   Harris and Beath prints, cadaver dissections, osteological material, gross measurements. References: Rossi, *Podometrics.* Wood Jones, *Structure and Function in the Human Foot.*

   This is a basic subject. Little is known of the various types of feet, and the development of the various types. Embryology and anatomy, with few exceptions, treat feet as if they are all alike. This is a project in which our colleges and our practitioners can contribute their part, after a plan of investigation is established. Merton Root has contributed much to new thought on this subject.

2. Relations of Pedotypes to Somatotypes.
   This is allied to No. 1, but relates body types to foot types.
   Reference: Sheldon — *The Varieties of Human Physique.*

3. The Sub-Astragalar Joint.
   Anatomy, anthropology, comparative anatomy and function with lower animals, physiology, roentgenographic studies, cadavers, means and variants.
   To me this is one of the most important joints in the human foot, for according to our present hypotheses much foot pathology originates in this articulation. It is the connection of the foot and the leg, and transmits weight in a time-motion sequence not found elsewhere in the human body.

4. Body Section Roentgenographic Studies of the Sub-Astragalar Articulation.
   Body section x-ray technique is a technique that enables one to blur out overlapping parts, and give an almost third dimension view to the part desired.
   Possibly the American Society of Chiropodical Roentgenologists could work on its development. It may have much to offer in the demonstration of foot pathology.

5. Weightbearing in the various pedotypes.
   It is now possible with modern electronic apparatus to more accurately measure the time-weight-motion sequences in the foot. This is very dramatic research.
   Unfortunately this is a costly line of investigation and much working space is required.

6. Tibial torsion in relation to foot types.
   Tibial torsion determinations and relationships to foot posture and pathology offer a new and pioneering field.
   Again this is investigation in the fields of anatomy, anthropology and physiology.

7. Genetic relations of Pedotypes.
   This is anthropological work of vast importance where very little has been done. Studies of fossil man and our ancestors would give us much knowledge as to the future of the human foot.

8. Heloma Durum.
   Since the epochal work of Sharp a few years ago, the subject has been badly neglected. It would be interesting to try and produce helomata on experimental

animals by sewing a button under the surface of the foot. The surgeons in our profession have much to contribute on this.

9. Ingrown toenails.
   Finding a dye that will stain only nail cells would be a big aid in assuring that no nail cells were left at time of surgery. This is a problem in applied and surgical research.
10. Hallux Valgus.
    So few basic facts are known on this subject that one could come up with some very valuable contributions here. We are missing something here, though at this time I cannot say what it is.
11. Orthodigita.
    This is one of the most interesting fields of treatment to be developed in chiropody in many years; the possibilities and uses are vast. Polokoff has given us an insight into it, but more needs to be done. I believe that chiropody has a chance to make an outstanding contribution in this field.
12. Morton's Neuroma.
    There is much conjecture but little knowledge of the etiology of this curious bit of pathology. A very cursory bit of investigation into this subject, a few cadaver dissections and some surgical cases, leads me to believe that the role the lumbricales and the interossei muscles play in the tensions and torques placed on the nerve by the rotation of the metatarsal head and shaft may be an etiological factor.
13. Growth and development of infants' and children's feet. We have some smattering of information in this field, but far too little. Perhaps something can be worked out along the lines of Wetzels' grids in this line. A very interesting line of research.
14. You will note that I have omitted any mention of verrucae, fungus infections or appliances (arch supports). Research into the etiology of verrucae is in the field of virology and histochemistry. While this is a very absorbing field, I feel certain that the huge expense in setting up such a laboratory is at present beyond our means. Also, who in our profession is trained in this work?
    Fungus infections in my opinion are more than a problem in mycology, but a problem in enzymes and bio-chemistry. The control of these infections, I feel, will be solved on the basis of what nutrients do fungi find on, and in, the skin, what bio-chemical action takes place there to allow them to survive, and what is a method of blocking this metabolism. This obviously requires persons trained in bio-chemistry. I may be wrong in my analysis of the problem, but that is the viewpoint from which I view it now. It will be interesting to see how the new oral drug, griseofulvin, will work in this problem.

The subject of arch supports or appliances is difficult to fit into any research niche. Most of it is so empirical, that it can go on and on, based upon hypotheses that are more assumptions than any demonstrable facts. The Levy mould and "balancer" type of therapy is at least an advance, and a new principle of foot mechanics seems to have been evolved. It seems obvious that basic research into several lines of foot pathology, as enumerated above, has more to offer toward making appliance therapy less empirical. Sir Edward Appleton[5] puts it nicely when he says, "A theory, by the way, is only a hypothesis that has become, so to speak, respectable. But even then there is nothing final about it." As J. J. Thomson once said, "A theory is a policy rather than a creed."

Where shall we do research?

The locations as to where chiropody research can be done are infinite. However, for our own professional gratification, we obviously want to do it ourselves in areas

of our own choosing and control. Obviously then our podiatry colleges should be the locale for such research endeavors as we wish to undertake. Unfortunately our colleges have many, many shortcomings in regard to research, but reflection upon their plight and problems in the past makes us realize that it could not be otherwise. When one is aware of the problems they have had and how much they have improved, the future cannot be anything but better. Each college must retain on a full-time basis as many competently trained individuals as possible in the fields of anatomy, physiology, anthropology (physical) etc. for teaching and directing research. These people should not be used as administrators, but as teachers and research people. They are not too plentiful, and the Alumni and their friends will have to provide the funds.

In lieu of adequacy in the foregoing, we need to organize and set up an Institute of Advanced Study for Chiropody at one of our colleges. Here basic research could be carried on, and members of our profession could go for say periods of one month and get suitable post-graduate or refresher courses. It would also be a center for all of the material one could need in chiropody research, have an adequate staff and a large library. At present there is not a place where such facilities are available. Surgery is about the only field at present where special training is obtainable.

We must realize that podiatry colleges are excellent for what they were intended, teaching podiatry. They were not organized for research, and the administrators have other problems. To set out now, as we propose, to explore the unknown, instead of teaching and defending what is present and past, takes courage, patience, and ability, and in general presents unsolvable problems presently to our college administrators.

Grants-in-Aid

Grants-in-aid are the time honored method of encouraging individuals in creative thinking, the arts, and scientific research. They have the advantage of the grantor knowing, at least tentatively, what projects the money is going for, and to the institution of his choice, usually a college or a university. Additionally, the grants place the responsibility on one individual for funds allocated.[6] As a rule, grants in aid are made by the grantee filing a request with the granting body, stating the proposed project, a very brief outline of the plan of work, where the work will be done and the funds needed. Such a grant is usually given on the basis that the grantee will work in the field requested, but may change his mind and work on another subject with the same funds if desired; this insures freedom of work if the original tentative ideas are not fruitful or other more promising lines or leads turn up from the original work. This latter is one of the more important factors in research administration, for to tie a man to one project is fatal; his freedom to think is destroyed. The grantor subsidizes a man's thoughts, ideas and brains, not his projects. As a rule, once yearly reports are required; any equipment purchased or constructed is usually left with the institution where the work is done. While this method may seem wasteful and extravagant, it has produced the best results so far; it is a calculated risk. For chiropody this is an ideal method.

Individual Research

All research is, of course, an individual matter. However, the term is also used to denote research people who work on their own, not in universities or institutions. More of it is done than most people realize, but the publicity the large universities, foundations and institutions get overshadows them. Many people cannot work under the stress of group direction. While

many of our men may be located in such a way that they have no facilities, this should not be a detriment. I believe you can work in your own garage on some projects as well as a large laboratory. It depends on the individual.

Fellowships

Fellowships are another method of giving research workers help. Usually they are granted by large corporations, foundations, institutions, and universities and colleges. They are usually granted to trained and qualified people for advance study. We have no mechanism whereby chiropodists can do this, but the role of the suggested Advanced Institute for Chiropody in such a manner is obvious. Any of our colleges would obviously also give fellowships in research if they had the funds to ask qualified men to pursue certain lines of research. This is obviously something we need.

Let me conclude with an excerpt from Weinlands'[6] excellent article . . . "the inherent nature of science and technology is such that a major accomplishment may be likened more to a cathedral than to a single arch, in that the complexity of the cathedral requires the construction of many arches and the assembly and organization of much supporting material. Unlike the cathedral, however, it cannot be planned in advance, and the need for the second arch may not be visualized until the role and the construction of the first have been clearly seen. Thus investigation proceeds in interlocking cycles, often with one accomplishment standing useless until a subsequent complements it, or with several in process at the same time, each taking shape in conformity with the others."

1651 Garnet Street

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"It is a comfort that the medal has two sides. There is much vice and misery in the world I know; but more virtue and happiness, I believe."

Thomas Jefferson

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

A SIMPLIFIED TECHNIQUE FOR DUPLICATING ROENTGENOGRAMS

ROBERT E. WEINSTOCK, Pod.D.*
Fresh Meadows, N. Y.

A PODIATRIST often finds it necessary to obtain a copy of a roentgenogram that is in his files. He may need a duplicate to send to a consultant, or he may desire a duplicate for surgical or orthopedic reports. If the doctor does not wish to send his original roentgenogram, he must of necessity have his plates duplicated at a photography or photostating shop. If, however, the doctor is ambitious and has the necessary equipment, he may duplicate his films by using one of many complicated techniques. Miniature copies of roentgenograms for projections may be obtained by using a copying camera loaded with either color or black and white film. In using the former film an exact duplicate is obtained. However when using black and white film, an opposite reproduction is obtained. These black and white negatives can be used to print enlargements which would approximate the original size of the roentgenogram. The enlargements† would be made on photographic paper which cannot be viewed on an x-ray film illuminator.

The following simplified and inexpensive method of roentgenogram duplication has been tested at Civic Hospital, Detroit, Michigan, and has proved to be very satisfactory for reproducing x-ray plates. This procedure can be performed in any normal x-ray developing room.

A portable x-ray viewbox is placed on a table or work space, with the illuminating surface facing upwards. All lights in the darkroom are extinguished, except for the safelight. The roentgenogram to be duplicated is placed directly on the opal glass of the viewbox. One sheet of unexposed screen x-ray film† (protective paper removed), is placed directly over the x-ray plate to be duplicated. The four corners of these two plates are matched and an empty cardboard x-ray cassette is placed over these films, and pressed firmly against the viewbox. The cassette will keep the surfaces of the film in direct contact, and will help to produce a sharp duplication. With the film and cassette held firmly in place, the illuminator light is switched on and the film is exposed for seven seconds, and then turned off. The exposed sheet of film is now placed on a developing hanger, and developed for approximately one half the normal developing time. Practitioners who are familiar with the technique of "sight developing" will find this technique of particular advantage.

After the film is developed, fixed, and washed it will be found to be an *exact* duplication of the original roentgenogram, and it can be viewed in the same manner as any other roentgenogram. There is no reversal of contrasts as is to be found in prints of roentgenograms.

The viewbox used contained two—fifteen watt fluorescent tubes, and could accommodate a 14" x 17" x-ray film. It was found that x-ray film illuminators equipped with incandescent bulbs did not provide the intensity, diffusion and quality of light necessary for good duplications. In using a

*Formerly Surgical Resident, Civic Hospital, Detroit, Mich.
†The author prefers Ansco High Speed (Screen x-ray Film) for this purpose.

fluorescent viewbox it is advisable to wait until both tubes are lit before timing your exposure. If bright spots or areas appear on the duplicate they may be caused by "hot spots" in the tubes, and it will be necessary to shift the position of the x-ray film during duplication, or replace the tubes with new fluorescent tubes. You may also wish to change the fluorescent starters frequently, so that the interval between illumination of both tubes can be decreased. This is necessary because both tubes do not light simultaneously. Instant starting fluorescent lighting will overcome this problem.

These rules of exposure apply to roentgenograms of normal contrasts. If a film is very dark the exposure time is increased, and conversely if the film is very light the exposure time is decreased.

Any practitioner who has an x-ray unit and developing facilities can make his own roentgenogram duplications. These duplicates can be made at a fraction of their previous cost, and without purchasing complicated and costly copying equipment. The duplications obtained have the contrasts of the original roentgenograms, and can be viewed in the same manner that original x-ray films are viewed, with any x-ray film illuminator.

61-10 183rd St.

MULTIPLE NEUROFIBROMATA

DENNY E. GAMBLE, D.S.C.
Shreveport, La.

A Case History:

On December 26, 1953, a white female, 46 years of age, appeared in my office complaining of acute pain in both feet. After x-rays, examination, etc., it was concluded that she had an acute foot strain.

History and Examination

The patient experienced acute pain in both feet after standing for a short period. The condition had been acute for approximately two months with slight intermittent attacks occurring over the two previous years. At the end of each day and when wearing certain shoes, the patient's back and legs ached and cramped.

Physical Signs Were:

Talo-navicular ptosis; feet swollen; veins dilated; redness in and around metatarsal area; depressed inverlongitudinal and anterior metatarsal arches.

Radiographs revealed, on lateral projection, a slight elevation of the periostium on the plantar aspect of the calcaneus and the posterior surface exhibited slight spurs. There was abnormal alignment of the metatarsals with saucering process on the dorsum of bases, suggestive of pronation syndrome. An abnormal cyma line was also observed. On the dorso-plantar view the following observations were made: exostoses on the first MP joints; valgus of forefoot; abnormally wide joint spaces; short first metatarsal; slight demineralization; sesamoids displayed laterally; several exostoses on metatarsal bases suggestive of traumatic arthritis.

Routine urine and blood examination revealed no significant information.

Course and Treatment

The patient was given physiotherapy and My-B-Den®[1] 20 mgm. once a day for ten days. Appliances were dispensed, with proper footgear. She was treated at different intervals in conjunction with her family physician with B^{12} and ACTH until October 28, 1955. At this time another x-ray and reevaluation was made and a diagnosis of bilateral neurofibromata between the fourth and fifth metatarsals was established. Surgical intervention was recommended, and on the 29th of October, 1955, surgery was performed. Neurofibromata, bilateral, were excised from between the fourth and fifth metatarsals.

The patient had a normal recovery and returned to work in approximately three weeks. The pain persisted in the left foot. By injecting Xylocaine®[2] into the area of

®[1] Ames ®[2] Astra

the third and fourth metatarsals, a diagnosis of neurofibroma between the third and fourth was made. Also an exostosis on the distal end of the fourth metatarsal was found. On April 20, 1956, a neurofibroma was excised. The exostosis on the distal end of the metatarsal was also excised. The patient developed an acute phlebitis of the right leg, which was treated while she was in the hospital with no residual symptoms.

On November 1, 1957, the patient returned with similar symptoms in the right foot. Again with the aid of Xylocaine injections between the second and third metatarsals, another diagnosis of neurofibroma was made. Due to complications which occurred in the right leg, we deemed it necessary for this patient to continue wearing appliances and proper shoes for relief of symptoms.

She still has acute symptoms periodically, but is able "to get by" now that she has changed jobs.

Remarks

Frost's[1] paper recalled this case to mind and is presented in the hope that it will be informative. This case would indicate that multiple neurofibromata can occur bilaterally. Are some individuals prone to the development of neurofibromata in the presence of pathomechanical problems?

326 E. Kings Highway

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DYSHIDROSIS vs EPIDERMOPHYTOSIS
A Case Report

SAM D. ZEBRACK, D.S.C.
St. Louis, Mo.

THIS is a case report of a patient who sought medical advice for several years and who entered this office with relutance. Mr. M., age 20, appeared for examination November 18, 1958 and seemed resigned to his condition which amounted, in his own words, to "some kind of fungus infection."

The patient's description of his condition, and the onset of flare-ups causing him trouble, he depicted as occurring in the summer, late fall, start of winter, and early spring. Examination of the patient's feet revealed extreme exfoliation and fissuring of both feet on the plantar, extending from heel to toe, and dorsally approximating the outline of a lowquarter shoe. None of the characteristic signs of an active fungus infection seemed to be present, and this appeared to be a case of dyshidrosis. However, as pointed out by Greenbaum[1], "Differentiation from dyshidrosis is difficult. The two conditions may occur simultaneously; however, freedom from recurrence of the vesicular eruption after elimination of the primary epidermophytic focus is conclusive evidence that one is dealing with dyshidrosis."

Since the patient had been treated many times for this condition with poor results and since there had been an absence of vesicular eruptions over the past several months, an exact history was sought to differentiate a possible dyshidrosis from epidermophytosis, which is often impossible without culture studies[2].

Mr. M. is a baker and during the busy seasons he assists in placing things in the oven. Since the busy seasons are July 4th, Thanksgiving, Christmas, and Easter, it seemed possible that the patient's flare-ups could be associated with the excessive heat given off by the oven.

Though the patient's feet were crusted and extremely dry, we learned that excessive sweating was a problem and that his feet were not always in the condition in which they now appeared. Further questioning disclosed that though the lesion had started with blebs and small blisters, an earlier professional visit had resulted in the lesion being diagnosed as a fungus infection. The blisters healed as the result

of prescription then applied. Since that time he obtained the job at the bakery and found that his feet did not respond to the same therapy.

Most of the practitioners Mr. M. had seen since, gave the same diagnosis and similar therapeutic measures with little if any response.

We informed the patient that his condition would be treated not as a fungus infection but would attempt to improve the exfoliation and fissuring and, if the response to therapy was not satisfactory, a culture would be made to ascertain the presence of fungi.

On November 18, 1958, the patient was given formalin 5%, and instructed to use this liquid morning and night for one week. The possible connection of the oven and the patient's crusted feet was discussed, and though a different occupation seemed indicated, baking was the only thing Mr. M. could do and yet support his wife. He was advised to attempt to take other duties in the bakery and stay away from the heat of the oven.

On November 25, 1958 the patient returned with feet flaking at the slightest touch, though according to the patient they felt better than they had in months. However, "The maintenance of normal epithelial structures is a major function of Vitamin A. In Vitamin A deficiency, the fundamental change is a keratinizing metaplasia, manifested in the skin by roughness, dryness and local eruptions which involve the feet, legs. . . ."[3]

The patient was at this time put on Aquasol A Capsules®[1], 50,000 units per day, as well as a prescription for Aquasol A Cream®[1] which was to be applied nightly the first week while the patient still used the formalin in the mornings. The second week the patient was instructed to stop use of the formalin and use the cream morning and night.

December 9, 1958, Mr. M. displayed normal skin on both feet, except for small areas beneath the metatarsal heads and beneath the heel. The patient at this time was instructed to continue taking Vitamin A Capsules for 4 weeks, and the use of the Aquasol A Cream. At the patient's last visit both feet appeared normal with patient's confidence restored.

Summary

It is hoped that this case history will indicate the difficulty in differentiating dyshidrosis from epidermophytosis. Of importance is an accurate case history. It is important to make diagnosis and a common error to accept a previous opinon without careful evaluation. The effectiveness of the use of Vitamin A in cases of dry, exfoliated skin is illustrated.

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®[1] U. S. Vitamin Corp.

"Men are born with two eyes and one tongue in order that they might see twice as much as they say."

Roman proverb

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PRESIDENT'S PAGE

Dateline: Paris, France
October 10, 1959

This is a brief outline of my tour of the Medical Centers of England, France and the U.S.S.R., in order to meet the deadline before the November Journal goes to press. I expect to have a more complete report, with illustrations, in a subsequent issue.

As requested of me by the resolution passed at the 1959 House of Delegates of the Association, I attempted to represent our profession in these areas as part of our State Department's "People to People Exchange Program."

As a preamble to this outline, I must acknowledge with grateful thanks a few of the many new friends who have made this trip the exciting, interesting and eventful experience it has been: In England, especially to John R. Hall, President of the Society of Chiropodists of Great Britain, who took ten days from his own practice to guide us through Britain; S. G. Shipper, Secretary of the Institute of Chiropodists, for his many courtesies; Franklin Charlesworth and Brigadier R. D. Ambrose. In Russia, to Professors, Drs. Priorov, Chucklin, Yzakov, Michellin, Butrov, and Mr. Vladimir Bobkin, Chief of American-British Section of Intourist. In France, to R. Ducrey, P. Monet, Drs. Lelievre and Bureau, and all the others about whom I shall later report.

Our film, "The Podiatry-Chiropody Clinic on Hospital Routine," by Dr. Raymond Locke, was shown throughout Europe and created unusual interest. The film strip, "Little Johnny Sorefoot," was shown and copies presented to medical leaders, as a gift of the American Podiatry Association. In the words of President Eisenhower, "I know of no better single method of reaching mutual understanding than by multiplying our international contacts through people to people diplomacy."

Immediately after inauguration as your President, I sailed aboard the S. S. Nieuw Amsterdam to England with Mrs. Shapiro and Miss Catherine Clarke. The following was my itinerary:

1. Conference with A.A.A. Moore, Esq., Secretary of the Royal College of Surgeons; Dr. Grey Turner, Secretary of the British Medical Association, and Brigadier General R. D. Ambrose of Smith, Kline and French in the British Empire, at the Naval and Military Club.

We discussed Foot Health practices in England and Health programs in general.

2. Train to Nottingham. Delivered a lecture on American Podiatry-Chiropody Practice and Association before the Midlands Branch of the British Society, at the University of Nottingham, Nottingham, England.

3. Flew to Manchester. Visited Manchester Foot Hospital and School, Peel Park Technical College, School of Chiropody, Manchester, England.

4. Visited and lectured at Hope Hospital, Manchester.

5. Conference with Professor Boyd, England's foremost Cardiovascular Surgeon; Mr. Sydney Rose, eminent Manchester Surgeon; Dr. Mark Swerdlow, prominent British Anesthetist; Franklin Charlesworth, prominent British Chiropodist, Chief of Chiropody Service at Hope Hospital; Mr. Ralph Creer, one of Great Britain's foremost Orthopedists and friend of British Chiropodists and outstanding Foot Surgeon, and last but not least, Mr. John Hall, President of the Society of Chiropodists of Great Britain.

6. Visit to London Foot Hospital and conferences with leaders of educational facilities of chiropody.

7. Lectured to membership of the Institute of Chiropodists at the Royal College of Nursing, London.

8. Conferences with leaders of British Chiropodists, including S. G. Shipper, Secretary of the Institute of Chiropodists; John H. Hanby, 1st President of the Society of Chiropodists and John R. Hall, present President.

9. Presented with Honorary Degree, Fellow of the Institute of Chiropodists, London, England.

10. Visited a number of hospitals and private surgeries in England and studied Medical Care Programs in general. Reception and dinner by the Executive Board of the Society of Chiropodists.

11. Jet flight to Moscow via Paris.

12. Invited to visit and lecture at the Hospital for Traumatology and Orthopedics, in Moscow, with approximately 125 foremost Orthopedists of the U.S.S.R. in attendance.

13. Conference with Professor Dr. M. M. Priorov, Dean of Orthopedists of Russia, and Chief of Staffs of 19 of Moscow's leading hospitals and medical centers.

14. Visited and lectured at Biotkin Hospital, 1,000 Bed Orthopedic Center. Conferences with Professor Dr. Yzakov, outstanding Russian Orthopedist. Keen interest in Foot Surgery shown. Detailed study of Foot Practices discussed before an audience of approximately 90 Orthopedic Resident Surgeons.

15. Visit and lecture at Hospital for War Veterans and Crippled Children. Conferences with Professor Dr. Chucklin and Staff. Special interest shown in Foot Appliances and Shoes.

16. Visited and photographed Research Centers concerned with developments in Prosthetic Devices.

17. Visited and photographed Laboratories fabricating Foot Appliances and special Orthopedic Shoes.

18. General Conferences with Physicians and Surgeons regarding Staff Medical Programs.

19. Russian Jet to Paris.

20. Conferences at Bureau D'Accueil of Foreign Ministry of France.

21. Meeting with R. Ducrey, Chiropodist, only French member of the Amer-

ican Podiatry Association and P. Monet, Dean of the Institute National De Podologie.

22. Conferences with Dr. Jean Lelievre, Chief of Clinical Surgery to the Faculty of Paris, and Dr. George Bureau, one of Frances's foremost Orthopedists who limits his practice to Forefoot Surgery.

23. Attended UNESCO Congress of Orthopedic and Traumatic Surgery at UNESCO Headquarters, Paris, France.

24. Attended Surgical Exhibition of Dr. George Bureau. Witnessed six Surgical Procedures of the Forefoot.

25. Visited to the School of Podologie, Paris, France.

26. Presented rare First Edition of Foot Care in France, printed in 1782.

27. Presented Autographed Original Manuscript, "Pathologie du Pied," by Dr. Jean Lelievre.

28. Presented Rare Prints of Feet by Dr. George Bureau.

29. Jet Flight to New York.

MARVIN W. SHAPIRO, D.S.C.

ORAL OR TOPICAL ANTIFUNGAL TREATMENT

The enthusiastic reports of investigators have projected griseofulvin into the limelight as an extremely important addition to antifungal therapy. In spite of the many dramatic successes obtained, many clinicians have some concerns. Can we safely assume that all the side effects are minor and transitory? Is there a possibility of developing resistant strains? What is the frequeny of recurrence of the infection after cessation of therapy? Is the efficiency of griseofulvin improved, impeded or unaltered when used concurrently with topical treatment? Of lesser importance to the clinician but of greater concern to the patient, is the present high cost of the drug, mounting rapidly in cases requiring protracted treatment.

Side effects observed to date have been heartburn, nausea, epigastric discomfort, diarrhea, and a few patients have complained of headache during the first week of a course of treatment. These have all been mild in character and are transitory. Therapy has had to be discontinued in only the occasional patient that developed urticaria. Experience to date would seem to indicate the drug's innocuousness but until hundreds of thousands and more have received the drug, it is advisable, as with all new agents, to have the patient under careful supervision, including blood counts regularly.

We have seen the development of resistant strains of pathogenic organisms in the case of other antibiotics and this is not unlikely here. Also griseofulvin is effective against certain dermatophytes and not others, notably Candida albicans. Griseofulvin dosing could lead to a resistant organism, multiplying fantastically in the absence of competition in the environment. These things should not deter us but require us to make a more critical diagnostic examination involving specialized mycologic technics.

Very little is known yet regarding recurrences, nor do we have information as to the length of time the griseofulvin remains in the keratin after cessation of ingestion of the drug. Presumably, the griseofulvin "grows out" with the nail plates and hair and with the desquamated skin. Prophylactic measures to eliminate or reduce reinfection are obviously indicated.

Many have suggested the concurrent use of topical treatment with griseofulvin. However, only on paper, and that in veterinary medicine, reports using a topical agent with oral administration of the drug. Since the drug is deposited in the keratin of the skin and the fungus is severely attenuated, and eventually succumbs, as it comes in contact with this agent in the skin, logic tells us that topical medication will shorten the course of treatment. This, of course, because of the savings, will be much appreciated by our patients.

The past month's issue (October 1959) of this journal had two interesting papers touching on presence of fungus in shoes and hose. One advised that our shoes could not be more than a minor factor in reinfection. The author suggested that hose should be shaken thoroughly to remove skin scales. The other paper described a product, combining a detergent and strong fungicide, that appeared to be the answer to sterilization of hose. A paper in this issue describes a study in which dusting powder in shoes, lowers remarkably the incidence of reinfection.

At this point griseofulvin should be used with discrimination. It should not be used for mild fungus diseases amenable to topical agents. Careful differential diagnosis should be made involving fungus culture tests if necessary. Griseofulvin should be given concurrently with topical agents for chronic skin and nail cases to shorten lengthy courses of treatment. Onychomycotic nail debris should be removed. Patient should be under regular and frequent supervision with peripheral blood counts made at suitable intervals. Treatment should continue until skin and nail scrapings are negative for fungi. Sanitization and sterilization of shoes and hose must be accomplished if incidence of recurrence is to be kept at a minimum. Daily dusting with an acceptable foot powder for prophylaxis should be insisted upon.

The ease with which we can write a simple prescription for this apparently remarkably effective, and non-toxic agent, should not permit us the luxury of inadequate diagnosis and inefficient treatment. In view of the still unanswered questions regarding griseofulvin, it would be particularly unfortunate if indiscriminate use were to lessen its full potential value.

A. R.

"The world owes all its onward impulses to men ill at ease. The happy man inevitably confines himself within ancient limits."

Nathaniel Hawthorne

APA Represented at Health Careers Conference

New impetus was given to national health agencies and professional societies to expand and strengthen their recruitment programs to meet health manpower shortages, at the Second Conference on Recruitment, sponsored by the Commission on Health Careers of the National Health Council on October 1-2, 1959, in New York City.

Dr. Alvin C. Eurich, Chairman of the Commission on Health Careers, and Vice-President of the Fund for the Advancement of Education, after reporting on the program of the Commission, emphasized the importance of developing still further the use of supportive personnel to conserve the time and energy of the professional person. "The record of the health professions is very good in this task of releasing the potential of professional personnel by supporting them with lesser trained but equally dedicated workers," Dr. Eurich said, "but it seems clear that much more must be done if we are to avoid deterioration of service because of the lack of professional personnel. We need to re-examine the tasks which can be done by the employment of paid or voluntary workers with the necessary interest, dedication, and abilities."

Speaking at the luncheon session, Dr. John D. Porterfield, Deputy Surgeon General, U. S. Public Health Service, challenged leaders in the health field to be more creative in tapping the large reservoir of talent and brains among the youth of our nation. . . . "I cannot believe in what someone has, I am sad to say, spoken of as the shallow national reservoir of talent. For example, only about 35% of our college-qualified youngsters ever complete college. . . . In many rural areas there may be a non-intellectual tradition as well as a residual psychic isolation which tends to shut off groups of young eligibles from the kinds of education which train for the professions. Finally, even in our presumably egalitarian society, there also remains a vestigial prejudice against female intellectualism. Males still comprise about two-thirds of the students in our colleges and universities. Here are sizable young populations with a substantial prevalence of mental capacity which have probably been exposed very lightly if at all to a career case-finding program."

The Conference brought together 75 representatives from 50 national agencies and professional societies for the purpose of exchanging recruitment experiences and exploring new programs and techniques. The APA was represented for the second year by Dr. Harry I. Horowitz, Chairman of the Council on Membership Development of the Board of Trustees, and for the first year by Dr. Seward P. Nyman, Assistant Secretary. "Work experience"—paid or voluntary—was examined in depth as a valuable aid in career choice. The problems and needs of the guidance counselor, and how health leaders can make more effective use of guidance counseling in promoting health careers was highlighted during the Conference.

Mr. James G. Stone, Executive Secretary, National Tuberculosis Association, and Chairman of the Conference, concluded the meeting saying: "We have come a long way from our first conference a year ago. I think most of our discussion has gone more deeply into some of the fundamental problems which we face in recruitment. We have gained by having the health agencies meet with the professional societies —by having participants from the 'Grass Roots' level, the guidance people and people doing some of the training. I am confident that the thoughts and ideas expressed will enable us all to continue to

work together to find solutions to the critical problem of manpower shortages in the health field."

This Conference is one of the many activities carried on by the Health Careers Program which was established in 1954 by the National Health Council for the purpose of finding solutions to the complex problem of staffing America's health services. The program has brought information about health careers to all of the nation's high schools and other places where young people seek help in making career choices. The Council reports that twenty-one statewide Health Career committees are active; 300 community-wide groups sponsor year-around programs; and thousands of communities are carrying on some kind of health career activity.

Health careers recruitment details developed at this Conference were: The best time to influence students is the last year of junior high school and the first year of senior high school. Scholarships create an important incentive. Much interest by all health professions was shown in programs designed to salvage for other health careers those who are unable to matriculate in the professional school of their first choice. The Paramedical Careers Recruitment Committee of the Women's Auxiliary to the American Medical Association invited the health professions to become more active at the state and local level with their very successful program. The New York, Pittsburgh and Richmond areas are most active with programs in health work for high school students during the summer months sponsored by the American Red Cross. Also, Civil Defense training is useful in interesting students in health careers. Guidance Clinics for parents designed to better equip them to advise their children are gaining in popularity. Dentistry reported that compared to the postwar peak less than one-half the number of prospective students for dental colleges was available for their Freshman classes this past fall. Also, the practicing dentist is the source of the largest percentage of students for the dental colleges.

NEWS OF THE PROFESSION IN GREAT BRITAIN

FRANKLIN CHARLESWORTH, F.Ch.S
Manchester, England

A regular series of "letters" about the profession in Great Britain, by Mr. Charlesworth, Editor of the British Chiropody Journal, will appear in this column.

DR. SHAPIRO VISITS BRITAIN

Chiropody in this country is just settling down to normal after the recent visit of Dr. Marvin W. Shapiro as part of his goodwill mission to Europe. It is hardly correct to say that we are settling down to normal. There is no doubt that the impact of his visit has gone down very deep and the many frank and fruitful discussions that took place between our prominent officials and your senior representative will at long last initiate positive steps towards full cooperation between the American Podiatry Association and the Society of Chiropodists. The process will no doubt be gradual but it will be no less positive and the end result will be to our mutual advantage.

Quite apart from his delightful personality which makes him a born ambassador, that which endeared him instantly to your British colleagues was his complete frankness in the discussion of the problems in your country and his quick and sym-

pathetic appreciation of those peculiar to us. Extensive and candid discussions which he initiated in a friendly and completely informal atmosphere could not have been better calculated to bring forth a reciprocal response from our officials.

Dr. Shapiro was ably supported by his charming wife and her friend Miss Clark.

Mr. John R. Hall, President of the Society of Chiropodists, put everything aside to entertain our honored guest, which resulted in the two presidents getting to know each other to an extent that had obviously, before the conclusion of the visit, brought forth real friendship and mutual respect.

Dr. Shapiro showed special interest in the National Health Service and its present and ultimate impact upon chiropody in this country. He was impressed by the exceptional clinical facilities available in the clinics associated with our schools. While there is a tendency to credit the exceptional number of patients available to students to the advent of the Health Service, this is not strictly true. Even under the old voluntary system most generous facilities were available to the public either completely free or for a very nominal contribution. Whatever the limitations in the scope of the British chiropodist he has never been starved of adequate clinical training.

Another aspect that I think impressed the doctor was the active and close association of eminent medical consultants with our schools. The profession of chiropody has developed in our two countries completely independently and as a result they have weaknesses and strong points peculiar to each. It is therefore obvious that when mutual cooperation on an official basis is ultimately established, our profession in both countries must benefit enormously. Therefore, it must be logically concluded that in this far-sighted mission of Dr. Shapiro to initiate steps for eventual international cooperation, there will be a corresponding increase in knowledge, status and mutual protection and above all a distinct and valuable contribution to international goodwill.

A most important factor is that not only will it be to the mutual good of our profession in all the countries concerned, but to the ultimate benefit of our patients, which is the most important factor.

We are also pleased to note that the Institute of Chiropodists organized an open meeting at Cowdry Hall, Cavendish Square, London. The meeting was thrown open to other chiropodists in addition to members of the Institute. The chair was taken by A. S. Hobbs, Esq., F. Inst. Ch., President of the Institute who introduced Dr. Shapiro to the attending practitioners. The doctor addressed the meeting in the informal, open and friendly manner to which many of us are now becoming accustomed.

We are sure that the meeting between Dr. Shapiro and the officials of the Institute was both informative and fruitful. In the course of the meeting, Honorary Fellowship of the Institute was conferred upon Dr. Shapiro.

Dr. Marvin Shapiro was most enthusiastically received by the rank and file in this country upon whom he made the best possible impression. He leaves us for the continuation of his goodwill mission, with the most sincere good wishes of all the chiropodists in this country, who sincerely hope that he will visit us again soon.

"Censure is the price a man pays to the public for being eminent."

Benjamin Franklin

TAX CLINIC

HENRY KENT, C.P.A.
New York, N. Y.

Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.

YEAR-END TAX STRATEGY

In the healing professions, prevention of disease is perhaps more important than the cure. Proper tax planning is also the most important step in legally reducing one's income tax by taking advantage of the various acts and elections under the Income Tax Law. Therefore, each year near the end of the year, a wise taxpayer takes stock of his income tax situation and determines whether he can take any steps prior to the end of the year in order to minimize his tax liability.

December is the month in which the sophisticated taxpayer can do much to lessen his tax burden since it is the last month of his taxable year if he is on the calendar year basis. The general rule is that the tax effects of transactions are governed by what was actually done rather than by what might have been done if there were alternate ways of closing or effecting a deal and the taxpayer will be subject to no criticism if he chooses the one which will save him taxes. Over and over, the courts have said it is only good business to consider carefully all alternatives legally available and choose the method which will keep taxes down. Here are a few suggestions to help you in your year-end tax planning:

Most professional men are on the cash basis — i.e. reporting income actually or constructively received and deducting expenses actually paid during the taxable year. It is often easier for the cash-basis taxpayer to shift income from one year to another than it is for a taxpayer on the accrual basis. Thus, if you are on a cash basis, you may be able to collect fees in advance from some of your patients or you may wait to bill them until after the first of the year if you would prefer to have the income in 1960. It is also easier for a cash-basis taxpayer to shift some expenses from one year to another. This is because time of payment controls the year in which he may deduct the expense paid. Thus, if you owe others money for services, repairs, supplies, interests, taxes, etc., you can accelerate or defer the time of payment of these expense items.

For example, a doctor has been very busy and has neglected to pay various bills for goods and services, such as office telephone, car upkeep and gasoline, pharmaceuticals, taxes on his home, etc. Although he has some leeway on these bills and could wait until January to pay them, he decides to make payments in December in order to increase his deductions this year rather than have the deductions in 1960. A word of caution, however, regardless of whether you are on the cash or accrual basis, you just cannot anticipate the tax deduction of an expense item by the simple expedient of making payments in advance for services to be performed at some future date. A typical example of non-deductible expenses would be advance payment of future office rent. The preceding limitations do not apply to advance payments of interests or taxes by a cash basis taxpayer, who, because of the wording of the code can deduct these items in the year paid. Thus, you could pay and deduct two years interests at once.

Capital gains transactions—December is a good month to examine one's investment portfolio and review the tax effects of the

sales already made during the year. As a general rule securities should be held for more than six months before their sale, but there are exceptions. If the losses are to exceed the gains, the holding period will be immaterial. If, in December, you find that your losses so far have exceeded the gains on securities, you might consider selling some stocks on which you have a gain and by offsetting same against the losses, you can avoid paying a tax on the gain. If you still have an unused net capital loss carryover from 1954, December 1959 is your last chance to use it. If by December you have not offset the unused carryover by 1959 Capital Gains, you should sell something at a gain, long term or short term, if possible, in order not to lose the benefit of the deduction. You might also consider selling your completely worthless securities in December to establish a loss. If you sell securities on a stock exchange on December 31, 1959 and delivery is made in due course in January 1960, a *loss* is deductible in 1959. A gain for a cash basis taxpayer on a December 31, 1959 stock exchange transaction is reportable the following year.

Here are some other helpful year end tax strategies: If your dependent (other than your child) has a small income—under $600 a year, make sure that the dependent's income is kept under $600 or you will lose the exemption. Even $1.00 may make a difference. If you are planning to marry, don't forget that if you are married on December 31, 1959, you can file a joint return for the year and split the combined income of yourself and your wife. The tax savings advantage should be sufficient incentive for the other party to move the date ahead to 1959 instead of 1960. But, if you can't do that, at least pay your bills, etc. this year and try to shift as much income as possible into 1960 (if you are on the cash basis) in order to increase your tax deductions and keep your 1959 income and tax to a minimum.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Hydrotox® Ointment

Description: An esthetic antimycotic agent specifically formulated for the treatment of superficial fungus infections. Hydrotox contains therapeutic concentrations of sulphur, salicyclic acid, undecylenic acid, and hexachlorophene in an oil-in-water emulsion type vanishing base that can be rubbed readily into the infected areas. It is pharmaceutically elegant, greaseless, and stainless.

Action and Uses: Hydrotox Ointment contains bacteriostatic and fungicidal components. The hexachlorophene provides bacteriostatic activity against the bacterial invaders that often complicate superficial fungus infections. The undecylenic acid aids in maintaining the normal fatty acid environment of the outer skin in addition to its antifungal action. The hydrophilic ointment base utilized in this product spreads a desirable level of keratolytic sali-

cylic acid activity and keratoplastic sulfur activity over the entire treated area, gently removing diseased tissue and promoting normal healing. Hydrotox Ointment, by virtue of its comprehensive formula, provides accepted therapy for athlete's foot, ringworm, and other superficial fungus infections.

Administration: A small amount of Hydrotox Ointment is gently massaged into the skin between the toes and other infected areas until the ointment disappears (about 10 seconds). It is applied twice a day, in the morning and again before bedtime after the feet have been washed and dried thoroughly.

Supply: In 1½ oz. tubes. By Zotox Pharmacal Company, Inc., 142 Hamilton Avenue, Stamford, Connecticut.

Hydrotox® Dry Spray Powder

Description: Hydrotox Dry Spray Powder is specifically formulated for use in conjunction with Hydrotox Ointment in the treatment of superficial fungus infections, and for use alone as prophylaxis. The powder, which contains salicylic acid, boric acid, zinc stearate, and exsiccated alum, is convenient and easy to use.

Indications: Hydrotox Dry Spray Powder is indicated for the prevention and control of superficial fungus infections, especially athlete's foot.

Administration: After the infected areas have been cleansed and dried, the powder is sprayed between the toes, over the foot, and on other affected parts. For easy and effective prophylaxis as well as therapy, the powder should also be sprayed into the shoes and socks.

Supply: In convenient 3-oz. flexible squeeze-spray containers. By Zotox Pharmacal Company, Inc., 142 Hamilton Avenue, Stamford, Connecticut.

Niatherm

Description: A non-toxic vasodilator and tissue stimulant. Niatherm tablets contain niacin in therapeutic dosage, plus vitamins B-1, B-2, and B-6, with iodine.

Advantages: Niatherm provides a safe, natural, non-toxic vasodilator and stimulant in tissue metabolism without undesirable side effects. The amino acid tryptophane, present in protein foods, is a precursor of niacin. Metabolic processes convert tryptophane to niacin, but nutritional deficiencies of vitamins B-1, B-2, and B-6 impair this conversion, as they are vital to this biological synthesis. These factors, present in the Niatherm formula, ensure maximum conversion and utilization of dietary tryptophane to niacin. This affords additional protection against niacin deficiency. Iodine is incorporated in Niatherm, as the thyroid hormone, thyroxine, is necessary to the maintenance of a normal rate of all metabolic processes. This hormone is 65% iodine, and a deficiency impairs the function of the thyroid gland, and the BMR becomes abnormal.

Actions and Uses: Niatherm acts as a safe vasodilator in conditions secondary to peripheral circulatory insufficiency, and in conditions where increased blood flow will bring relief. In high, but harmless dosage, the vitamin relaxes constricted blood vessels, oxygenates tissues, and metabolizes accumulations of toxic subtsances resulting from a diminished blood supply.

Indications: Buerger's disease, Raynaud's disease, intermittent claudication, varicose veins, leg ulcers (stasis), chronic cold feet, chilblains, and other conditions associated with poor blood flow.

Dosage: One tablet four times daily.

Supply: Bottles of 120 tablets. By Podiat-Rex, Ltd., Glendale, California.

"Put not your trust in money but put your money in trust."

Anon.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

DERMATOLOGY

Some Practical Aspects of the Diagnosis and Management of Shoe Dermatitis, A. A. Fisher. Arch. Derm. 79: 267-74, 1959.

In shoe dermatitis, the rubber either in the rubber thermoplastic box-toe or in the rubber cement is the cause of the allergic contact dermatitis. This sensitivity generally is due to the additives which are used, such as antioxidants and accelerators, or it may be caused by chromates, dyes, or nickel in the shoe. The rubber thermoplastic box-toe, found in most of the inexpensive oxford type of shoe, is composed of scrap (from old tires and girdles). Felt, turpentine, resin, rosin, styrene, asphalt, and Carbowax are added to the rubber, and then the antioxidants and accelerators. This thermoplastic box-toe is brittle, adheres poorly, and has a low softening point.

The dermatitis usually begins on the dorsum of the toes, especially the first toe in a patient who has worn inexpensive oxford shoes. Diagnosis of the contact dermatitis depends on the history of the case, the clinical picture, positive patch-test reactions to shoe materials, and the patient's ability to wear proper substitute shoes without developing dermatitis. Such patch-tests do not indicate other affecting factors, such as the leaching effect of sweating while the shoe is being worn, nor the effect of friction, or maceration. Not only are diagnosis and therapy necessary, but it is important also to inform the patient how to obtain shoes which are free from the specific materials to which he is sensitive.

A satisfactory shoe is one with a Celastic box-toe made of cotton flannel impregnated with pyroxylin (a cellulose nitrate, much of which is obtained from old eyeglass frames). This material has not been found to cause skin sensitivity, is not friable, adheres excellently, withstands high temperatures, and retains its shape however hot the weather, but is expensive. Patients who prove sensitive to rubber box-toes may wear soft-toe shoes—those with uppers of canvas, various cloths, plastics, or nylon mesh, if these shoes are not lined. The lining of shoes contains rubber cement.

The author describes a shoe-tray for patch-testing, which is used for 'screening,' and where such materials may be obtained. Negative reactions to these materials do not necessarily exclude shoe dermatitis. It may be necessary to test with materials from the suspected shoe.

Trivalent chomic sulfate, or hexavalent sodium dichromate used initially in tanning leather has been largely considered non-sensitizing. By patch tests, the author found 18 of 68 (26 per cent) persons had dichromate sensitivity. Small amounts of hexavalent chromate may not have been reduced in the tanning process, or it may have been used in dyeing the leather. Also, perspiration may leach chrome salts toward the outer surface of the leather. Some patients with dichromate sensitivity and dermatitis of the foot will benefit from wearing vegetable-tanned shoes, or non-leather substitutes. It is the inner leather lining, if any, that must be vegetable-tanned.

If a rubber insole is the cause of dermatitis, felt inner soles should be worn to prevent contact. Dermatitis on the instep due to rubber cement is rare; it is cured by wearing unlined moccasins or unlined

cloth or plastic shoes. Dye sensitivity is rare, except in redyed shoes. The original dye is usually 'fast.' Dermatitis can come even from fabric or plastic shoes with dyes which 'bleed.' However, this bleeding may come from stockings and enter the shoe lining. This secondary shoe dermatitis may confuse patch testing.

Nickel sensitivity occasionally comes from the nickel used on or in the shoes, for example, in the eyelets or on the tips of the shoe-laces, from buckles or metal clips; even from nickel arch-supports.

Shoe dermatitis may be prolonged by friction, sweating, or scratching. Treatment with tar products will help, or roentgen ray treatment may be required. Wearing of waxed paper, oiled silk, plastic paper bags, or aluminum foil inside shoes is uncomfortable and unsatisfactory. These materials tend to increase perspiration and maceration.

The author gives names and addresses of shoe manufacturers and dealers from whom shoes may be obtained which are free from certain known specific sensitizers. He suggests that patients with a shoe dermatitis be given a note describing the sensitizing agent, which he can show to the dealer.

Measurement and Maintenance of Natural Skin Oil, H. J. Spoor. New York St. J. M. 58: 3292-99, 1958.

Therapy of oil-deficiency syndromes requires correction, if possible, of the underlying cause, and conservation of the natural oil on the surface of the skin. Often the lesions require little more than restoration of the natural oil. The oil deficiency may be due to removal of these oils by soap, detergents, and water; to aging of the skin and decrease in oil replacement because of the inactivity of the sebaceous glands, particularly the glands of the nose and chin; the dry skin may be associated with an allergic-dermatosis of the atopic type, such as atopic eczema, or localized or disseminated neurodermatitis; or the oil deficiency may be a part of dry dermatoses such as psoriasis, seborrhea, and xeroderma. An oil deficient skin may be associated with a slow functional recovery of the skin after a generalized toxic eruption, or even with some disease off the glands themselves.

Methods for testing the quantity of oil in the skin are described, including use of osmic acid staining on litmus paper, and quantitative in vivo measurements of the skin surface oil.

A series of 40 office patients, all of whom had an oil deficiency dermatology, and had long been under various types of dermatologic treatment, received treatment designed to conserve the natural oil. In addition to the prescribed dermatologic therapy, emollient baths with a water-dispersible type of bath-oil were given as adjunct therapy, without the use of any type of soap. Some patients received daily baths over a period of weeks, months, or a year; others received two or three baths weekly over the same periods. This treatment in most instances, permitted restoration and conservation of the natural skin-oil, even in as dry a condition as eczema. Biopsy studies made of the skin in some cases before and after therapy showed the increase in stainable natural unsaturated oil.

Complete cure followed in a few patients, sometimes with recurrence which also responded to the treatment. Two patients with chronic seborrheic eczema received no benefit. One, a girl of 5 years, who had long been under dermatologic therapy for an allergic dermatosis, received the baths daily for 2 weeks without improvement. A man aged 21 with atopic eczema for 3 years failed to improve. The remainder, except for two patients who did not cooperate, were improved; some were greatly improved, one of whom, a man aged 58, had a seborrheic keratosis for 30 years, be-

coming progressively more severe, was greatly improved after daily emollient baths for a period of 6 months.

DIABETES

Peripheral Vascular Complications in Diabetes Mellitus: A Survey of 3,600 Cases. Kramer, D. W. and Perilstein, P. K. Diabetes 7: 384-87, 1958.

An analysis was made of the case histories of 3,600 office and hospital diabetic patients treated during the years 1921 to 1957. Particular attention was directed to the peripheral vascular system. The patients were divided into three classes: (a) those with impaired circulation, (b) those threatened with gangrene, (c) those with gangrene. The patients were of all ages. Vascular disturbances were found more frequent in females than in males in all these groups—in a ratio of 1:1.32. A high incidence of vascular complications, especially in the smaller arteries, was noted after 15 to 20 years of duration of the diabetes, in the younger patients. In older adults duration of the disease did not seem an important factor in development of these complications. However, diabetes may not be recognized in an individual until vascular disorders such as thrombosis or gangrene (in 129 of these cases) arise. The highest incidence of complications of the peripheral arterial system occurred in patients with diabetes of 1 to 2 years duration (314 cases). More than 60 per cent developed changes in the arterial system within the first 5 years of the diabetes; the next highest (165 cases) occurred in the 6- to 10-year group.

The highest incidence of vascular disturbance was noted in 539 patients with mild diabetes (those who can be controlled by diet alone, or in whom the daily insulin requirement is 20 units or less); 216 had moderate diabetes (those requiring as much as 40 units of insulin); 99 were classed as severe (requiring more than 40 units). The highest number of cases (348) with peripheral disorders occurred in the seventh decade age-group; next highest (296) in the sixth decade. Peripheral vascular disorders occur rarely in the young group (only 6 in the second and third decades).

This survey showed that there is an increasing incidence of vascular changes, although diabetes is being detected oftener in the early stages; also, constant efforts are made to control possible hypocholesteremia by low-fat diet and other therapeutic measures, yet the incidence of vascular pathology increases. It hardly seems justified to assume that diabetes *per se* is responsible for these changes. Nor is severity a factor, since most of the complications occur in patients with milder forms of the disease. Further study of metabolic disorders, besides those of cholesterol and carbohydrate, and of uric acid, may prove they are contributing factors. Since some forms of atherosclerosis are reversible, efforts should be made to determine the various causes promoting its occurrence. Meanwhile, it is advisable to continue rigid control of the diabetes, and to continue use of a low-fat diet.

DRUG THERAPY

Treatment of Acute and Chronic Arthralgias with a Tranquilizing Agent (Trilafon) in Addition to Prednisone or Prednisolone, E. Settel. J. Amer. Geriat. Soc. 6: 749-53, 1958.

Painful spasm of the involuntary muscles is increased by nervousness and apprehension. Fear of pain increases the functional limitation of motion beyond that which can be attributed to organic involvement. Primary disorders and prolonged disability are greatly increased by loss of sleep, by resentment of dependency, and fear of loss of earning power. Supplementation of basic adrenal steroid therapy by an effective tranquilizing agent can speed recovery.

Arthralgia of traumatic or inflammatory

nature in 21 ambulatory middle-aged patients and 29 hospitalized elderly patients was treated with Trilafon®[1] in addition to prednisone (Meticorten®[1]) or prednisolone (Meticortelone®[1]), in various strengths and doses. The highest dosage of the steroid was 5 mg. and the lowest 2.5 mg. four times daily. The highest dosage of the tranquilizing agent was 8 mg. and lowest 2 mg. four times daily. Fourteen of the 21 ambulatory middle-aged patients received Meticorten 5 mg. and Trilafon 8 mg. three to four times daily. Marked success was obtained in all; but one-half of them became somewhat drowsy. Meticorten 5 mg. with one-half the dose of Trilafon was successful in 17 of 19 and reduced the drowsiness 50 per cent. The two failures occurred in a case of traumatic hemarthrosis of the knee joint, and in a case of severe sacroiliac sprain.

In general, a lower dose of Trilafon combined with larger amounts of the adrenal steroid proved just as effective and less soporific. Of 29 who received Meticorten or Meticortelone 2.5 mg. and Trilafon 4 mg. four times a day, 25 were benefited and had no side effects. None of the patients had retention of fluid; a few elderly cardiac patients who received higher doses of both drugs had increased peripheral edema of the legs. Relief of pain was much greater when both Trilafon and a steroid were used, than with steroids alone. With the emotional element reduced, recovery occurred 30 to 40 per cent more rapidly. Prednisone and prednisolone reduce pain, inflammation, and swelling in disorders of the joints. The optimal dosage seems to be 2.5 mg. of the steroid and 2 mg. of Trilafon, three to four times daily, with larger amounts used in resistant cases, or for short term therapy. After maximal improvement is achieved, smaller doses can be used in maintenance therapy.

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MUSCULOSKELETAL SYSTEM

Management of Knee Injuries in Athletes, A. B. Lipscomb. J. Tennessee Med. A. 51: 369-72, 1958.

A report is made of 67 knee injuries treated over a 5-year period by the physician attending the athletic teams of a university, in which he advocates conservative management of such injuries. All but 3 of these players were rehabilitated to active participation in football games.

In this group of cases, 34 injuries were partial tears of the tibial collateral ligaments; complete recovery was attained in an average of 22 days. In 9 with severe tears of the tibial collateral ligament associated with injury to the anterior cruciate ligament, recovery occurred in an average of 52 days. Re-injury, in 5 patients, required 22 days for complete recovery. In 7 cases of partial tear of the fibular ligament and lateral joint, recovery was complete in 14 days; there was no re-injury among this group. Arthrotomy was required in 14 cases. An average of 6 months was required for complete recovery.

Analysis and Treatment of the Common Foot Disorders, J. C. Risser. Arizona Med. 15: 645-49, 1958.

This discussion deals entirely with flat foot. The anatomy of the foot is described, together with the role of the os calcis and toes.

Hallux Valgus in Adolescents, J. A. Chomeley. Proc. Roy. Soc. Med. 51: 903-906, 1958.

Various methods have been used in correction of this common deformity. Conservative methods have proved almost useless, such as use of hallux valgus splints, which can be worn only in bed; toe pegs between the first and second toes, which tend to push the second toe into valgus rather than correcting the first toe; and exercises which mobilize the feet and toes, but help the deformity very little. Correction of great

toe deformity requires surgery in childhood and adolescence, but the function of the foot must not be affected nor the surface of the metatarsopharangeal joint encroached upon or damaged.

Some of the numerous operative procedures are described and evaluated. The McBride method consists of removal of the lateral sesamoid, excision of the prominent medial portion of the metatarsal head, and transplantation of the tendon of the adductor hallucis into the metatarsal neck. This soft tissue operation is of value only in mild degrees of deformity; it does not correct metatarsus primus varus. Operations depending on further growth of the metatarsals to correct the deformity include that of Ellis, with stapling of the lateral side of the epiphyseal plate at the base of the first metatarsal. The Lapidus method calls for arthrodesis of the medial cuneiform-first metatarsal joint with simultaneous removal of a lateral wedge to correct metatarsus primus varus; fusion of adjacent surfaces of the first and second metatarsals is obtained by use of cancellous bone chips. The basal epiphysis of the first metatarsal should have been fused previously. Rocyn Jones designed an osteotomy of the proximal part of the shaft of this metatarsal to correct metatarsus primus varus, but relapse of the varus occurred in many instances, especially when growth was not complete at the time of operation. In such a case, an osteotomy correction can be maintained only by insertion of a bone graft on the medial side and the first and second metatarsal heads kept in close contact. A screw might accomplish this, as suggested by Bonney and Macnab.

In Stamm's operation an osteotomy of the base of the first metatarsal is performed and a graft obtained from the prominent medial part of the metatarsal head, or from a Keller arthroplasty, which is inserted through the neck of the first metatarsal. But even with the epiphyses fused, Keller's arthroplasty should not be carried out in children and adolescents, since a stiff metatarsophalangeal joint may result. Instead of transplanting the adductor tendon, the first and second metatarsal heads can be kept in close contact by use of nylon or catgut sutures around the second metatarsal neck and through and around the neck of the first metatarsal. Another, earlier operation by Hohmann was a transverse or oblique osteotomy of the neck of the first metatarsal, displacing the distal part laterally, without internal fixation. This was modified, by Peabody, by formation of a lateral peg on the distal side of the osteotomy, displacing it laterally, and fixed by catgut stitches through drill holes. This was further modified by Hawkins by removing a transverse 1/8 inch thick section from the medial side of the metatarsal neck, leaving the lateral peg as before and similarly fixed by catgut sutures.

In a report of 535 cases of hallux vagus operations (Mygind, 1952), and the various methods used, the best results obtained were by oblique osteotomy of the first metatarsal close to the head, by the peg method of Thomasen. Others disapproved of the results of this operation said to be due to too early weight bearing; the results were more satisfactory when weight bearing was avoided for four weeks. The operation can be done safely in children in whom the epiphyses are not united, and in adults having no gross radiologically evident arthritis. The operation consists of transverse or oblique osteotomy of the neck of the first metatarsal, and formation of a lateral plantar peg on the proximal fragment with bone nibblers; a hole is then drilled on the medial side of the distal fragment and the peg pushed into it. The foot is immobilized for 8 weeks; no weight bearing is allowed during the first 4 weeks. The patient is readmitted to the hospital for final removal of the cast and remains for one week while foot and toe mobilizing

exercises are taught; the patient is encouraged and is trained in correct walking. Roentgenograms show little callus formation.

Objections to this operation and to the Mitchell-Peabody method are: the shortening of the first metatarsal, the length of time in the hospital, and the long time in plaster. The chief advantages are: it corrects metatarsus primus varus and hallux valgus, without interference with the metatarsal phalangeal joint. In children, metatarsal osteotomy may be considered meddlesome surgery. But the only alternatives are: doing nothing even if the deformity increases and pain develops; or prescribing shoes with a straight inner border wide enough to accommodate the broad forefoot and bunion. The former is of no value and the latter probably will not be worn. Sensible shoes are disliked by young and old.

Industrial Injuries of the Foot, C. F. Steiss. J. Internat. Coll. Surgeons 30: 266-73, 1958.

A patient may have had a chronic foot disability which during his years of working has been aggravated by his occupation, by badly fitting shoes, by overweight, or other factors. The injury further alters the physiology of the foot. Surgeons tend to direct their efforts toward salvaging all that is possible in the limb, to replacing lost tissue by reconstructive surgery as much as is possible, and to obtain healing and restoration of the foot to as near normal as can be done. Once the patient is discharged from the hospital, the surgeon feels no further responsibility.

For rehabilitation of the patient, however, the therapeutic process ends only with recovery or successful reinstatement in a useful, remunerative occupation. To accomplish this should be the concern of the plastic surgeon who operated on the foot. Rehabilitation measures should be under his direction. Indiscriminate physiotherapy can produce harmful results. Heat and massage can be helpful if skillfully administered. Whirlpool baths can stimulate healing, or can retard it by maceration of the skin. Complaints of pain should be evaluated to avoid complications that will delay the cure. A pressure point can cause ulceration of the flap, or development of a callus. A trigger point can initiate causalgia. Tender scars must be protected from faulty weight bearing, and contractures must be relieved.

"The whole man must be treated"; overweight should be reduced, and posture improved and care given for general well being. The patient must be encouraged to help himself. Proper footwear to support and correct an injured foot requires impressions taken of the foot for accuracy in fitting. Many chronic ailments of the foot are involved in determining how well and for how long the patient can function in his work. Cooperation between the attending surgeon and the employer is essential. Such coordination is only slowly developing in this country. It could be accelerated through education, and by cooperation between medicine and industry, "each having much to learn from the other."

A Patient Solves Own Foot Drop Problem, V. R. Ford. Phys. Ther. Rev. 38: 483, 1958.

A woman, who was a post-poliomyelitis patient, for cosmetic reasons wanted to discard her short-leg brace. The question was how to obtain adequate dorsiflexion to eliminate the steppage gait. At her own suggestion, a sturdy, low-heel oxford type of shoe was obtained and, after various weights were tested, 11 ounces of lead were inserted into the posterior aspect of the leather heel, and then polished to look like the shoe leather. This weight, for her particular size of foot and ankle, acting on the axis of the flail ankle joint, pulled the heel downward, and lifted the toe up-

ward, so that an almost normal heel strike was obtained. When her various gaits, without the supporting device, with the short-leg brace, and with the weighted shoe, were compared, it was found that the weighted heel afforded a better cosmetic appearance, eliminated the supportive device, and provided a good gait.

Localized Gigantism, C. Markland. Canad. Med. J. 78: 605, 1958.

A case of gigantism of the second toe of the right foot is reported in a 65-year-old woman. Her husband had seen the deformity only two or three times; she succeeded in concealing it from all other members of the family. She cut a large hole in an extra large pair of shoes to allow room for the very long toe with its huge end. The condition had only recently become very painful, due to development of a bunion and calluses. She requested amputation. The toe was amputated together with removal of the exostosis over the head of the first metatarsal. The results were satisfactory. A suggestion is made that this abnormality may have been related to a congenital arteriovenous fistula. Only in a rural community could such a deformity be allowed to exist for so many years.

Foot Problems, J. P. Harvey. New York State J. Med. 59: 851-58, 1959.

Various foot disorders and their treatment are described, such as clawtoe, hyperextension of the 5th toe, hammer toe, neuroma, ingrown toenail, bunion, osteoarthritis, hallux valgus, flatfoot, weak foot, everted foot with spasm, spur, tender bursae, plantar wart and rheumatoid arthritis. In attempting to cover so many conditions in so few pages, the author has necessarily oversimplified considerably.

NEW GROWTHS

Granuloma Pyogenicum: Differential Diagnosis, L. Rowe. Arch. Derm. 78: 341-47, 1958.

This benign tumor occurs at any age on various parts of the body; among the preferred sites are the hands and feet. Usually they are about 1 cm. in size, but may be 4 to 6 cm. They are vascular tumors, red to brownish-red in color, with smooth, frambesiform surface, and firm, pedunculated or sessile. They are not tender or painful, but bleed readily and suppurate. Onset is insidious, then they grow rapidly to maximum size, when growth stops; but they persist indefinitely without any tendency to heal. Usually an unequivocal diagnosis is obtained histopathologically. Occasionally, the growth is difficult to distinguish microscopically from other benign or malignant vessel-element neoplasms. Its bizarre clinical appearance is suggestive of malignancy.

Granuloma pyogenicum may clinically resemble a sarcoma, benign or malignant angioma, epithelioma, or melanoma. For this reason, the lesion is apt to be examined microscopically, and its benign nature revealed. Many lesions have been described as resembling granuloma pyogenicum, but later found to be some other benign or malignant growth.

To determine the need for biopsy in all such lesions, a study was made of the records of 59,737 specimens submitted for biopsy over a 5-year period. Of 124 clinically diagnosed as granuloma pyogenicum, the microscopic diagnosis differed in 47 cases (38 per cent). Some proved to be benign or malignant tumors; some were merely some type of skin lesion. Any lesion, therefore, resembling granuloma pyogenicum should have this clinical impression confirmed by biopsy.

Keratosis Punctata Palmaris et Plantaris. M. Y. Ansari. J. Indian M. A. 30: 410-13. 1958.

This comparatively rare idiopathic disease of the palms and soles has been recognized since 1879, but for the first time is reported in Indians. Five cases are described, all alike histologically, but differing in clinical

features. In two cases there was a history of the anomaly in other members of the family. The affection was painless and symptomless. The nodules on the hands and/or soles were noted in four patients when they were admitted to the hospital for other diseases, two for congestive heart failure and two for pleural effusion. The remaining patient was in apparent good health, except for these lesions. The patients, aged 40 to 60, had observed the presence of the nodules for 20 to 40 years. One patient had the nodules removed by a barber five years ago; another had a barber remove them annually; they always returned in two or three weeks. In one case there were about 225 nodules on each palm. Only one patient had the lesions on the palms only.

PHYSICAL MEDICINE

Arthritis: Use of Physical Therapy as an Aspect of Management, E. F. Reese. California Med. 89: 204-09, 1958.

In treating the inflammation of arthritis by steroids, gold, and salicylates, physicians forget other effects of the disease—contractures, muscle atrophy, deformity, osteoporosis—which the patient may relieve while carrying out the activities of daily living. In many cases the inflammatory stage can be controlled by physical measures—use of heat, hydrotherapy, ultrasound, exercises, avoidance of trauma, and carefully planned rest. (Joint tuberculosis and malignant disease must be ruled out first.)

Heat may be applied locally or generally (except to a limb with arterial insufficiency), to relieve spasm and pain, to dilate vessels, increase circulation, improve tissue metabolism, and hasten absorption of exudates. (a) Luminous heat (electric lamps) is valuable in all stages of rheumatoid and osteo-arthritis. A 250-watt bulb with reflector may be used at home, or a luminous baker with four 60-watt bulbs. (b) Paraffin baths at 130° F. are recommended for hands and elbows. *(Ed Note: Author advises against paraffin baths for the feet, though this is a common practice of many podiatrists-chiropodists.)* After heavy coating with the paraffin, the part remains in the bath for 30 minutes, or is wrapped in towels. For home use 16 blocks (4 pounds) of paraffin are melted in one cup of mineral oil. (c) Short-wave microwave diathermy is not advisable in treatment of acutely inflamed joints. (d) Application of moist packs containing a colloidal gel filter, which has absorbed water during storage in a thermostatically controlled tank, is applied for at least 30 minutes.

Ultrasound therapy decreases arthritic pain, muscular spasm, and swelling and inflammation of joints. It can be used after injection of steroids to aid dispersion. Apply 1/2 watt to 1 watt per sq. cm. from a moving source.

Ultraviolet therapy is used to relieve psoriatic arthritic skin lesions. Rheumatoid spondylitis may be relieved of pain and inflammation by roentgen therapy, together with intensive breathing and postural exercises. Irradiation is contraindicated. Arthritis due to lupus erythematous may be exacerbated by exposure to sunlight or ultraviolet rays.

Therapeutic baths are of various types. (a) Thermal baths at a temperature of 100° F. to 103° F., with the patient covered up to the shoulders, are given for 10 minutes; their effects are vasodilatation, increase of cardiac rate, metabolic rate and peripheral circulation; encouragement of diaphoresis, absorption of exudates, and diuresis; relieves muscle spasm and pain. The patient is wrapped in blankets after the bath, gradually cooling for 30 minutes. Contraindicated are tuberculosis, heart disease, dermatophytosis, and heat prostration (b) Whirlpool baths are used for the extremities for their massaging action. They are given at 110° F., unless debilitated, then given at 105° F. They decrease pain and spasm, and permit an increased

range of motion and exercise during immersion. (c) Thermic pools are useful for exercising, and aid early ambulation. They allow passive exercises in the pool. In cases of open wounds or a draining infection, an antibacterial emulsion is added to the water. (d) Contrast baths are not too effective in rheumatoid arthritis. The extremity is immersed at 100° F. for 10 minutes, then at 60° for 1 minute; then hot water for 4 minutes; cold water for 1 minute alternately for 1/2 hour. They must be used with caution for patients with tendency to peripheral vascular disease.

Therapeutic exercise is required throughout life. (a) Passive exercises are described; they must be preceded by heat to reduce pain and bring relaxation and vasodilation. (b) in assistive exercise the patient is assisted by the therapist, or by use of mechanical devices. (c) Resistive exercises are for muscle building. A few repetitions against maximum resistance, contracting all muscle fibres before fatigued, is better than many repetitions. They are not contraindicated by active joint inflammation. (d) Flexion and extension of joints should be slow, and complete each time. (e) Special exercises are described for the vastus medialis, carrying the knee through the last 10 degrees of extension and locking it.

Rest periods should be scheduled for the arthritic patient during the day; sufficient sleep should be afforded at night. Absolute bed rest without exercise is harmful; the joints must be kept moving. If the patient will not, or cannot, do active or assisted exercises, passive exercises should be done through full range of motion, even in case of severe inflammation.

Traumas to be prevented include: excessive weight, weight bearing on unstable or flexed joints, poorly fitted shoes, poor posture, occupational stress and psychic stress. Also, lying in bed with knees and elbows flexed; having a pillow under the knees, causing contractures. The patient should lie flat, with a footboard and/or cradle to support blankets and prevent foot drop, with pillows or sandbags along the lateral aspects of the lower extremities to prevent rotation of the hip; arms semiflexed, with elbows and wrists straight. Splinting for relief of spasm and deformity must be adapted to the degree of deformity.

Occupational therapy includes psychic therapy to relieve depression and anxiety; kinetic occupational therapy to maintain an increasing range of motion and muscular strength of the affected parts. The objectives of rehabilitation efforts are helping the patient to become a wage-earner and an active member of society.

SURGERY

Osteotomy of the Calcaneum for Pes Cavus, F. C. Dwyer, J. Bone & Joint Surg. 41-B: 80-86, 1959.

Pes cavus in children develops sometime after the age of three, depending on whether it is of idiopathic or neurologic origin. In its early stages it can be well controlled by a metatarsal bar. In many patients the deformity progresses to dropping of the forefoot, to contracture of the plantar fascias, to clawing of the toes and callosity formation, and gradual development of a varus deformity of the heel and forefoot. As the heel becomes adducted, the calcaneal tendon acts as an invertor, pulling largely on the inner border of the heel. The varus deformity increases because the child walks on the outer border of his foot. With the heel thus in varus, weight bearing cannot stretch the plantar fascias, and contracture results.

A new surgical approach is described which overcomes these deforming influences by shifting the heel into valgus position, thereby allowing weight bearing to correct the deformity. After subcutaneous division of the contracted plantar fascia, a wedge 8 to 12 mm. wide is removed from

the calcaneum just below the peronus longus and inserted, the wedge tapered down to the medial cortex, which is broken to insure complete closure of the gap. The forefoot is pressed up into dorsiflexion against the pull of the calcaneal tendon, to bring the bony surfaces well together. Nonclosure will be due to leaving a small piece of the apex behind.

By approaching the deformity from behind and overcoming the varus of the heel, the foot becomes plantigrade, so that weight bearing exerts an influence producing progressive improvement of the deformity. This is a prophylactic operation, and best performed before gross structural deformity develops, and while active growth is going on. However, this simple operation will also afford improvement in patients beyond 14 years of ago. In adults having a high fixed arch, gross varus of the heel and forefoot, and clawing of the toes, a large lateral wedge is removed from the tarsometatarsal region to bring full correction of the distorted foot. A longer time is required to achieve sound fusion than with a midtarsal wedge.

Since 1952 when this procedure was first described, the author has performed the operation 63 times in 41 children, aged 3 to 16 years. Correction of dropping of the forefoot and clawing of the toes followed, producing improvement in gait and in shoe-wear. In 6 heels the operation had to be repeated at intervals of 6 to 18 months, because of some vagus deformity, possibly because the initial wedge was too narrow, or because of recurrence due to muscular imbalance following poliomyelitis or other diseases.

In older children with a long established deformity of the foot, flattening of the longitudinal arch can be demonstrated some time after correction of the heel. The degree of correction depends on the time of the operation and strength of the bones. The operation overcomes the problem of excess wear on the outer side of the shoe, and allows the toes to straighten out if malleable, and preserves movement at the midtarsal-subtarsal joint.

The Problem of the Painful Scar, J. C. White. Ann. Surg. 148: 422-32, 1948.

Partial injury to peripheral and intercostal nerves results more often from the surgeon's knife than from accidental injuries. They can lead to serious disburbance of the patient physically and mentally, because painful scars become intensely disagreeable with paresthesia distributed widely over the injured nerve, or the nerve caught in the scar. The disturbance often occurs after incisions which damage superficial radial, intercostal, or saphenous nerves. The majority come from injury to intercostal nerves at the time of thoracotomy incisions, and from operations on the extremities. Infected wounds are no more likely to result in these painful complaints than those healed by primary union.

Of 2,962 veterans examined for peripheral nerve injuries, 529 complained of hyperalgesia three to seven years after neurolysis or suture had been performed.

In one of the cases described, severe neuralgia followed midline posterior calf incision, made to obtain a biopsy specimen of the gastrocnemius muscle for suspected trichinosis. Any other site would have avoided injury to the sural nerve. The woman complained of painful tingling paresthesia when the skin was touched over the malleolus joint and the outer side of her foot as far down as the little toe. A surgeon knows the importance of care in handling the principal sensory-motor nerves to the arm or leg, but few pay attention to the intercostals or superficial nerves to the extremities. Fortunately they do not generally give rise to troublesome complaints. But painful complications can follow scarring of these nerves. Surgeons should make every effort to avoid unnecessary injury to these structures, and to avoid

them in the course of routine surgical incisions. Precautions should be taken not to bruise, stretch, or cut regional nerves, or to include one in the closing suture. The saphenous and sural nerves should not be damaged in operations for varicose veins, for dislocated semilunar cartilages and by incisions in the ankle and leg.

Treatment of cicatricial injury of nerves is very difficult. Relief may be possible only through major neurosurgical procedures. Efforts should be made to relieve these conditions before the patient becomes addicted to opiates, or is psychologically disturbed. Once post-traumatic neuralgia is established, spontaneous remission is rare. Sympathectomy is useless in these cases. Excision of sensitive end-bulbs, neurolysis, proximal neurectomy — all usually fail.

In the present series of 25 patients, there were a number of disheartening failures; few had long-lasting benefit. Operations were performed on 21; two of them required a second operation to obtain relief. After resection of the neuroma or of the posterior spinal roots, relief might be obtained in some for a short time, but pain recurred within several weeks or months. Only fourteen obtained satisfactory relief.

MISCELLANEOUS

Current Trends in Atherosclerosis Research, J. H. Bragdon. Arch. Indust. Health 18: 222-27, 1958.

Atherosclerosis is characterized by a narrowing of the small arterioles by muscle hypertrophy and fibrosis, and by deposition of fat and fibrous tissue in the intima of the aorta, coronary, cerebral, and other arteries. It is now the leading cause of death in this country. Because of the increasing incidence of this disease in men aged 20, 30, and 40, many writers have considered it a metabolic disorder. It has long been suspected that cholesterol plays a role in the pathogenesis of atherosclerosis. Most of the cholesterol in human serum is contained in the beta-lipoprotein of the serum. The cholesterol in an average American almost equals the phospholipid in the total plasma; in individuals with more than average amounts of beta-lipoproteins, plasma cholesterol exceeds the phospholipids.

In patients with hypercholesteremia the cholesterol levels are decidedly varied. This Council in another long-term project studied a large cross-section of the population in regard to dietary, smoking, and drinking habits, blood pressure, weight-height measurements, and serum cholesterol levels. These were correlated with the appearance of clinical evidence of cardiovascular disease. The report at the end of the first four years stated that three factors seem to predispose to coronary disease: elevated serum cholesterol, obesity, and hypertension. Of 900 men, aged 45 to 62, 52 had developed evidence of coronary artery disease (A ratio of 50 per 1000). In those with the highest cholesterol levels, the ratio was 122 per 1000. Among the 20 per cent who were most obese, the ratio was 114 per 1000. When these two factors existed together, the incidence was 143 per 1000.

Efforts have been made in the last 15 years to lower serum beta-lipoproteins (and therefore cholesterol levels) by injection of heparin, and other drugs. None of these was too helpful. Next came avoidance of cholesterol in the diet, the diets very low in all fats or an avoidance of all animal fats. Recently, various writers have emphasized that the degree of saturation or unsaturation of fatty acids in the diet determines whether serum beta-lipoproteins increase or decrease. Until it is established that atherosclerosis is the result of ingestion of too much fatty acids, it is foolish to recommend a drastic change in the dietary habits of the American people.

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

CONNECTICUT

Dr. Bernard D. Sherman of Stratford, has been reappointed by Governor Ribicoff to the Connecticut Board of Examiners in Chiropody for another three year term. Dr. Sherman is a past president of the Connecticut Podiatry Association and is currently serving on the Board of Directors. He is a Fellow and Past President of the American Society of Chiropodical Roentgenology.

IDAHO

The largest group of podiatrists ever to assemble in Idaho met at Sun Valley September 11-13, 1959. Representatives from California, Oregon, Washington, Utah, Wyoming, Illinois and Montana helped swell the attendance to a new record. Among the speakers at the meeting were Dr. Harry D. Lawson of Seattle, who lectured on "Lateral and Medial Muscle Tension and its Diagnosis and Treatment"; Dr. C. L. Stoker, Salt Lake City, on "Use of Plastics in Balance Therapy"; Dr. M. Nuddleman of San Francisco, on "Medico-Legal Aspects of Practice"; Dr. Ray Kingland of Boise, on "Surgical Intervention in Tension Problems."

The following officers were elected: President, E. Joseph Yacks; Vice President, Frank Partridge; Secretary-Treasurer, Charles W. Sykora; A.P.A. Delegate, Ray Kingland; Alternate, Max D. Harris; Regional Delegate, Jack Franden.

The Association retained the services of an Attorney as Legal Counsel and went on record to assist the Civil Defense Mobilization Program under the direction of Terrell O. Carver, M.D., Administrator of Health, State of Idaho, who addressed the combined group.

Awards for Research Papers

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1st Award - $200.00 — 2nd Award - $150.00 — 3rd Award - $100.00

Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1960.

Podiatrists Position in Civil Defense Mobilization Team

Idaho Public Health Department Administrator, Dr. Terrell O. Carver, accepted an offer of assistance from members of the Idaho Podiatry Association in the Civil Defense Mobilization Team today. The scope of their assistance and role of aid was defined. The individual podiatrists will be expected and prepared to fill an important part in the event of local or state-wide disaster.

Dr. E. Joseph Yacks of Coeur d' Alene, President of the Idaho Podiatry Association, appointed Dr. R. M. Kingland of Boise as Liaison Officer to represent the podiatrists on the State Committee under Dr. Carver's administration which plans and supervises Medical Civil Defense activities. This action was representative of similar programs in effect in other states. Under emergency conditions the podiatrists will be expected and prepared to clean and treat wounds, splint, bandage, assist in major surgery, administer medications by needle, administer vaccines for immunizations, treat shock, relieve pain, and perform emergency treatment to open chest wounds.

ILLINOIS

Zone III

Zone III of the Illinois Chiropody Society met in Galesburg, Illinois on September 12 and 13. On the scientific program, Dr. Robert Gottler of Monmouth, presented "The Use and Technique of Moulding Plastic Inlays by Use of Rhodur"; Dr. J. Lorentzen of Rock Island, presented "Symptoms, Diagnosis, and Treatment of Cuboid Faults"; and Dr. Fred Sauerman of Moline, presented "Treatment of In-toeing and Out-toeing by Use of the 'Twisters'." Dr. Gottler was awarded the annual trophy for the best presentation.

MINNESOTA

The annual state meeting of the Minnesota Podiatry Association was held at Rutgers Pine Beach Resort near Brainard, Minnesota on September 11-13, 1959. The

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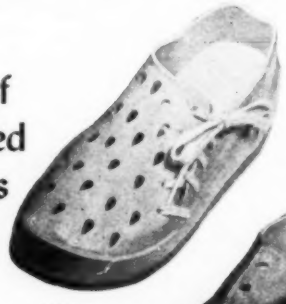
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Minnesota Academy of Foot Surgeons (not affiliated with the American College of Foot Surgeons) conducted its quartely seminar with Dr. Lyle McCain of Chicago as guest speaker.

Lester Dale, M.D., of Red Lake Falls, Minnesota, was presented an Honorary Life Membership in the Minnesota Podiatry Association for his unselfish service in the promotion of better public and interprofessional relations.

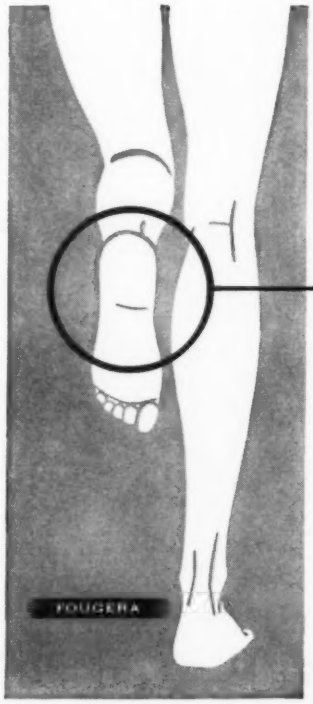
Elected to office were: President, Thomas O'Keefe, St. Cloud; Vice President, William Perendy, Mankato; 1st Vice President, Keith Jorgenson, Red Wing; 2nd Vice President, Ann G. Rotramel, New Ulm; Secretary-Treasurer, Robert E. Ray, Minneapolis; Delegate, Thomas O'Keefe; Alternate, Don Peterson, Crookston; Delegate to Region Six, Ann Rotramel; Alternate to Region Six, John Frankson, St. Paul; Recording Secretary, Harry L. Merrill, Minneapolis; Sergeant-at-Arms, David O'Connor, Minneapolis; Outgoing President, Edward Chrencick of Hopkins.

The Minnesota Podiatry Association conducted its annual children's examination booth in the State Education Building at the Minnesota State Fair this year. More than thirty podiatrists participated in this project. Over 800 children were examined.

NEW YORK

The publication of a foot care story in the October issue of McCALL'S (reading circulation 12,700,000) marked another major accomplishment in the continuing public information program of the New York State Podiatry Society.

Dr. Milton Werbel, President of the Podiatry Society, in announcing the "newsbreak" to the membership of the Podiatry Society stated, "The advance proofs I have received from the editors of McCALL's leave no doubt in my mind that the handling of this article is dignified, factual, and presents the podiatrist as the unquestioned authority on problems of the feet." Dr. Werbel also recommended that each practitioner obtain a copy of this article so that



in dry skin disorders

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SINGULARLY EFFECTIVE where the many have failed.

Repeated failures demonstrate that oily or greasy agents are not the answer. Clinical evidence[1-2] indicates that the rehydrating and lubricating action of POLYSORB HYDRATE is the effective approach to dry skin therapy.

POLYSORB HYDRATE is a specially processed hydro-dispersant emollient consisting of sorbitan sesquiolate in a wax petrolatum mixture. Available in 50 gram tube and 425 gram jar.

1—Feldman, B.: Dry Skin, It's Cause And Treatment, J. Amer. Pod. Assn., May, 1958

2—Freeman, D. W.: The Dry, Scaly, Fissured and Eczematoid Skin, J. Amer. Pod. Assn., Feb., 1959

E. FOUGERA & COMPANY, INC., Hicksville, Long Island, New York

it could be utilized as waiting room literature.

In extending his congratulations to the New York Society's Public Relations team of Dr. Benjamin C. Mullens, Dr. Benjamin Kauth, and Mr. Gilbert Hollander, Executive Secretary, Dr. Werbel pointed out that the last year has seen thirteen major releases issued by the New York Society which have been used as the basis for magazine articles, newspaper features, and special Sunday supplement stories in newspapers throughout the country.

The McCALL'S article was particularly noteworthy in that it adopted as its theme "See Your Podiatrist—Foot Specialist" as the answer in almost every case where problems concerning proper foot care were discussed. In both the body of the article and in the Question and Answer section which followed the article, foot problems which affect millions of Americans were discussed intelligently and in excellent taste.

The role of the podiatrist was very clearly shown and there can be no doubt that the millions of McCALL readers received a valuable public health lesson.

OKLAHOMA

Southwestern Chiropody Congress

The Southwestern Chiropody Congress invites you to attend its annual convention to be held at the Skirvin Hotel in Oklahoma City, Oklahoma, June 20-23, 1960. Outstanding scientific lecturers and fun for the whole family.

PENNSYLVANIA

Philadelphia

The Philadelphia Chiropody Society met at the Philadelphia County Medical Society Building on Tuesday, September 15, 1959. Dr. L. M. Lindenberg of Lansdale, gave a preliminary report on "Grifulvin" and "Highlights on Chiropody in England, Europe and Israel."

Northwestern Division

A meeting of the Northwestern Division, Chiropody Society of Pennsylvania, was held at Luthersburg, on Sunday, September 20, 1959. President Chester Rossi was

Stimulate Ethical Increase of Income

Increased dispensing . . . increased patient referrals . . . increased income—Easy as One . . . Two . . . Three

The doctor, who increases the scope of treatment will increase his practice. Many doctors have proved that dispensing Chiropody Prescriptions increases the satisfaction of the patients with the treatment they receive. This leads to increased referrals by the patients to their family, neighbors and friends, resulting in new patients.

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"THANK YOU, DOCTOR"

CHIROPODY PRESCRIPTIONS INCORPORATED

Since 1945

Originators of Ethical Dispensing

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host. Following dinner, reports were given on Legislation by Dr. Huels; Membership by Dr. Pankratz; Public Relations by Dr. Fletcher. The new parliamentarian, Dr. John Ziegler, was introduced by Dr. Rossi. Among the guests were Drs. R. W. Baum of New Castle, Philip Gorman of Indiana, Fred Bove and Leo Nelson of Erie. Scientific session featured a representative of Merck, Sharp & Dohme who presented a film and talk on narcotics, their dosages, storage and procurement. Question and answer period followed.

Following the meeting, members, their wives and guests enjoyed a social hour at the home of Dr. and Mrs. Rossi in DuBois.

AMERICAN COLLEGE OF FOOT ORTHOPEDISTS

At the recent Annual Dinner Meeting of the American College of Foot Orthopedists, held at the Waldorf-Astoria on Sunday, August 30, the following members were elected to serve as national officers for the year 1959-60: President, L. B. Thompson of Kenosha, Wisconsin; President-Elect, Murray Bromberg of Bloomfield, New Jersey; Vice Presidents, Jack Stern of Chicago, Illinois and Herman L. Siegler of Levittown, L. I., New York; Secretary, Joseph R. Cinzio of Passaic, New Jersey; Treasurer, D. A. Goodwin of Marion, Ohio; Trustees, George C. Custer of Chicago, Illinois, Allan S. Cutler of Cicero, Illinois, Arthur E. McGrady of Waltham, Massachusetts, William A. Edwards of Reno, Nevada.

At the Annual A.C.F.O. Meeting preceding the dinner, plans were formulated for

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HEMOSTATIC-SOLUTION
FOR TOPICAL APPLICATION

BACTERIOSTATIC

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FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS

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the A.C.F.O. Scientific Exhibit to be displayed at the National A.P.A. Hall of Science in Chicago in 1960. The following received their Fellowship certificates: Robert R. Jacobs of Theinsville, Wisconsin; Floyd Frost of Toledo, Ohio; Arthur E. Helfand of Philadelphia, Pennsylvania and Joy E. Adams of St. Petersburg, Florida.

A meeting of the new Executive Board will take place at the Mid-West Conference to be held at the Morrison Hotel in Chicago, March 25-27, 1960.

REGION I MEETING

The recent Region I meeting was the largest meeting of the New England states. Closed circuit television featured a scientific program. Illustration was taken at one of the scientific exhibits and shows (L-R) Dr. Arthur O. Roberge of Fitchburg, Massachusetts, podiatrist, U. S. Army Hospital, Ft. Devens, Massachusetts; Dr. Earl Kaplan of Detroit, Michigan, director of Civic General Hospital, Detroit; Dr. Sidney Heller of Milford, Massachusetts, retiring president of the Massachusetts Podiatry Association, and Dr. James F. O'Connor of Hyde Park, Massachusetts, Veterans Administration, examining the U. S. Army exhibit at the 8th Annual Conclave of the American Podiatry Association's Region I meeting in Boston, Massachusetts.

(Official U. S. Army Photograph)

Thanksgiving Day is a jewel set in the hearts of honest men. But be careful that you do not take the day and leave out the gratitude.

E. P. Powell.

FOOT BALANCE INLAYS

are only completely
successful
when each case
is individually studied, diagnosed
and an inlay made to fit its
special requirements

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originator of foot balance inlays is directed
in all its endeavors to accomplish this result

VACATION-EDUCATION IN MAGNIFICENT MEXICO

THE AMERICAN COLLEGE OF FOOT SURGEONS ANNOUNCES ITS

First International Meeting

Del Prado Hotel, Mexico City, Mexico

January 11, 12, 13, 1960

PROGRAM

Dr. Robert Brennan
Dr. John Collet
Dr. I. P. Foreman
Dr. Ralph Owens
Dr. Ned Pickett
Other Outstanding Foot Surgeons

A SPECIAL PROGRAM FOR WIVES. Your wife is an asset to your practice. **Dr. H. L. Collins** of Columbus, Ohio will be the speaker.

A POST-CONFERENCE LECTURE AT ACAPULCO. For those who desire additional knowledge, the meeting will recess and reconvene at Acapulco, January 15, 1960. **J. T. Slayback, M.D.,** of Glendale, California will make the trip worthwhile.

HIGH POINT OF THE CONFERENCE. A day at the **National University of Mexico.** Speakers from the faculty of its renowned medical school.

REGISTRATION FEE: Members—$15.00; Non-Members—$25.00. Advance Registration Fees should be sent to Dr. William Edwards, 150 Arlington Street, Reno, Nevada.

TRAVEL ARRANGEMENTS and HOTEL RESERVATIONS: Elliott Travel Service, 18657 Livernois, Detroit 21, Michigan.

GUADALUPE SHRINE

FIRST INTERNATIONAL MEETING AMERICAN COLLEGE OF FOOT SURGEONS

The American College of Foot Surgeons is arranging an ambitious international program January 11, 12, 13, 1960, at the Del Prado Hotel, Mexico City. The meeting will recess and reconvene at Acapulco for further lectures for those who wish to take advantage of visiting both cities as part of the one conference. A feature is a special program for the wives by Dr. Collins of Columbus, Ohio, who will talk to them about the "Wife As An Asset to the Doctor's Practice." Some of the speakers are: Drs. Robert Brennan, John Collet, I. P. Forman, Ralph Owens, and Ned Pickett. In Mexico City, one day will be spent at the National University of Mexico, with speakers from the faculty of its renowned medical school. J. T. Slayback, M.D., Glendale, California, will be the speaker at Acapulco.

ACAPULCO

This meeting will provide an opportunity for doctors and their wives to combine a very pleasant vacation with a real opportunity to improve their practice potential and service to their patients.

Skin Adherent No. 2

(Improved Formula)

The finest adhesive for felt, gauze, tape and moleskin

ASK YOUR DEALER

The Mowbray Co., Waverly, Iowa

HOSPITAL SERVICE NEWS

Memorial Hospital of Queens has established a residency in podiatry. First residency started October 5, 1959 and is Harold Mandell, Pod.D., graduate of M. J. Lewi College of Podiatry, 1959.

The hospital will train 12 residents a year, each serving a one month period. His hours will be 7:30 A.M. to 5:00 P.M., with 24 hour emergency call nights and weekends.

Resident will scrub in and assist on all podiatric and orthopedic surgery to the extent possible and will observe other surgery. He will make rounds and do complete foot examinations, with recommendations on all podiatric, orthopedic, general practice and obstetric and gynecologic

CHIRO ADHESIVE PLASTER

a premium quality product

- Water repellent
- Maximum, unvarying adhesion and tack
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Write for our Catalog of Chiropody Specialties: Molefoam, Moleskin, Kurotex, Adhesive Felt, Adhesive Felt Padding, Adhesive Foam, Foam Padding, Tubegauz.

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patients. The hospital provides living quarters, meals and a living stipend of $50.00.

The Podiatry Department at Memorial Hospital is deeply grateful to Otto Gitlin, M.D., founder of the hospital, for making this residency program possible.

APPOINTMENTS

Laurel Heights State Hospital

Andrew S. Anastasio, Pod.D., of New Haven, Connecticut, has received an appointment to the Laurel Heights State Hospital, an institution designed to care for patients afflicted with Tuberculosis and other chronic illnesses.

Mercy Hospital

George F. Haigh, Jr., D.S.C., of Woonsocket, Rhode Island, has been appointed Chief of Podiatric Surgery, Mercy Hospital.

D. C. General Hospital

Dr. Paul Miller has been appointed to Civil Service position of Podiatrist for the District of Columbia General Hospital. Dr. Miller is a recent graduate of the Ohio College of Chiropody.

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The olive oil base is the secret to your insurance of a satisfied patient. It relieves pain.

The finest adhesive for felt. It remains flexible.

Sold by all supply houses

The Griswold Salve Co.
Hartford, Conn.

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After extensive research, a new accurate molding technique for contour shoes has been perfected. Quick-Cast®, using a gelatinous mold completely safe to the skin, is easily performed in 15 minutes. Personal Contour Shoes, made from this casting technique, are custom-crafted of the world's finest leather. Guaranteed to fit perfectly.

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Specialists in the Finest
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ULTRASOUND	STOOLS
SINES & DIATHERMIES	LAMPS
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WOMEN'S AUXILIARY MESSAGE

In Membership There Is Strength

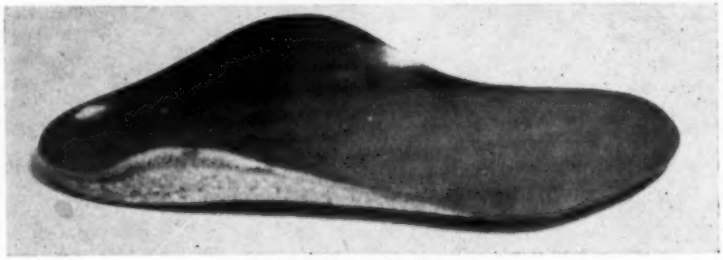
In numbers there is strength. But, unless strength is utilized, it is of little or no value. The full realization of value from the strength of a large Women's Auxiliary requires more than just activity. It requires action that emanates from worthwhile projects and activities.

All officers and committee chairmen are already at work to make this coming year one of the best for the Auxiliary. In making our plans, we have kept uppermost the purpose of the Auxiliary which is to be of assistance socially to the American Podiatry Association and to promote and interest others in matters pertaining to the profession of podiatry-chiropody.

We request that you urge your wife to become a member of the Auxiliary. We need her and we sincerely believe that we will be of assistance to her and to your profession.

MRS. CLEOTHA PARHAM, President

SAVE 2/3 of Your Laboratory Cost!



Style #2423 — Semiflexible

New, doubly reinforced, long length inlay, designed to cover the whole ball of the foot for easy forefoot balancing. Fully corked up and ready for balancing by grinding in your own office. Puts you in control with your better knowledge of your patients' needs. 53 sizes carried in stock for immediate shipment.

STYLE #423—Semiflexible—Molded leather shell. Same as #2423, but without cork on bottom.

STYLE #413—Flexible—Molded leather shell. Same as #423, but lightly reinforced.

Technique sheet, size run, and prices available upon request.

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Vosburg *Foot Appliance Company*

Austin 1, Texas

LEGAL AND LEGISLATIVE

INDIANA

Recent state legislature passed a Radiation Control Act. Section 15 of this act reads as follows:

"It is hereby declared unlawful for any person to operate or maintain within this State any fitting devices or machines which use fluoroscopic, X-ray, or radiation principles for the purpose of fitting or selling footwear through commercial outlets."

DEATHS REPORTED

Anthony Gattuso
Teaneck, New Jersey
H. B. Bronston
Detroit, Michigan

Dr. Bronston died recently after 38 years of practice in Detroit. He was a past president of the National Association of Chiropodists and the Michigan Chiropody Association. Dr. Bronston was 62 years of age at the time of his death.

ASC CUSHIONING

your most complete cushioning service created especially for the podiatry profession

- ENERGY ABSORBING FOAM
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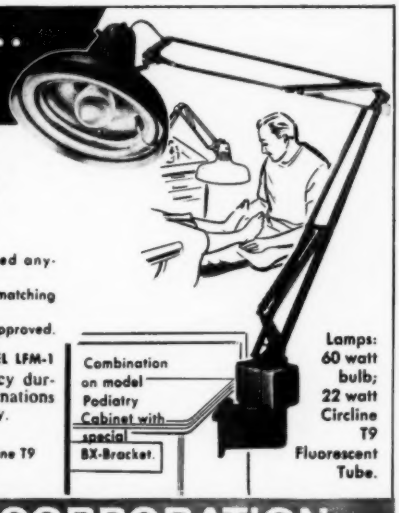

The "Combo" balances incandescent and fluorescent light in one fixture—the closest thing to natural daylight! Ideal for diagnostic work. Either light can also be used individually.

LUXO FEATURES...

- Adjusts to any position and stays put! Moves out of way when not in use.
- Comfortable to work under.
- Can be mounted anywhere.
- In modern lab matching colors.
- UL and CSA approved.

MAGNIFYING MODEL LFM-1
For visual accuracy during medical examinations and minor surgery.
Lens: 5" diameter
Lamp: 22 watt Circline T9 Fluorescent Tube
Color: Grey

Lamps: 60 watt bulb; 22 watt Circline T9 Fluorescent Tube.

LUXO LAMP CORPORATION

CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Chicago, Ill., Aug. 27-30, 1960
Drake Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
New York, N. Y., Feb. 19-21, 1960
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Philadelphia, Pa., May 5-8, 1960
Sheraton Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Mid-West Conference
Chicago, Ill., Mar. 25-27, 1960
Morrison Hotel
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Omaha, Neb., April 1-3, 1960
Sheraton-Fontenelle Hotel
Drs. Harold G. Wieseman and Ken C. Nielsen
640 City Natl. Bank Bldg., Omaha, Neb.

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Williamsburg, Va., Nov. 13-15, 1959
Williamsburg Inn
Dr. Leonard Kaplan
718 Court St., Portsmouth, Va.

Region Nine
(Florida)
Dr. E. B. Hurd, Gen. Chairman
623 DuPont Blg., Miami, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Dr. G. Burnham Peterson
Doctors Building, Marietta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Oklahoma City, Okla., June 20-23, 1960
Skirvin Hotel
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Western Podiatry Congress
Long Beach, Calif., May 27-28, 1960
Lafayette Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

Canadian Podiatry Association
Dr. L. Hurwitz, Exec. Sec.
3017 Bathurst St., Toronto, Ont.

American College of Foot Surgeons
First International Conference
Mexico City, Mex., Jan. 10-13, 1960
Hotel Del Prado
Dr. Lawrence Frost, Convention Chairman
Kresge Bldg., Monroe, Mich.

New Mexico Podiatry Society
Carlsbad, N. Mex., Jan. 23-24, 1960
La Caverna Hotel
Dr. Leon Cohen, Program Chairman
306 N. Canal St., Carlsbad, N. Mex.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

IN AUGUST 1960

IN CHICAGO, ILLINOIS

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

The head of the house reported to the police station that he had been struck on the head in the dark outside his back door by an unknown assailant.

The precinct captain sent a young rooky officer to investigate. In no time at all he was back and growled, "I solved the case."

"Good boy, fast work! How did you do it?"

The rookie gently rubbed the lump on his forehead. "I stepped on the rake too."

The two lady travellers, visiting western Canada for the first time, had stepped out of the train to stretch their legs on the station platform. Seeing a man lounging against a baggage truck, one asked, "What place is this?"

"Saskatoon, Saskatchewan," he replied.

As they turned away one lady whispered to the other, "Isn't it exciting? They don't speak English here."

Five children sent this letter to the Seattle Post-Intelligencer: "Our dad says juvenile delinquency is the result of parents trying to train children without starting at the bottom."

"There are three kinds of politicians," said former Congressman Calvin Johnson of Illinois, "the kind that can't tell a lie, the kind that can't tell the truth and the kind that doesn't know the difference."

INSURE
RECEIVING YOUR
JOURNAL
WITHOUT INTERRUPTION
PAY YOUR DUES NOW

DR. POD By Bob Hughes, D.S.C.

"He says he has Health Insurance, Doctor!"

Overheard at the National Press Club:

"The best argument for strict immigration controls is to take a look at what the Indians did to this country when they let in people like us."

The only place where one word should lead to another is in a book of synonyms.

We got to talking the other night—you know how it is when the TV goes on the blink.

Everybody should pay taxes with a smile. Only trouble is, the Guv'ment wants cash.

"Than drinking and driving
There's nothing worse.
It's putting the quarts
Before the hearse."

Help Fight TB

Use Christmas Seals

A Navy recruit on his first sea trip was taking an examination for promotion. One question was: "In the event of a leaky tube in the boiler what steps should be taken." The recruit wrote: "The boiler room ladder—two steps at a time."

———

This gem was told by a lecturer at the New York State Meeting.

"My nine-year-old daughter," he said, "wanted to know where babies come from, I fumbled and bumbled and did my best but when I had finished she said, 'But I still don't see how the seed gets from the daddy to the mommie.' I fumbled and bumbled some more, then from the next room came the voice of my *seventeen*-year-old daughter: 'Go on, tell her, you big coward.' "

———

Teacher had asked the class to make a list of who they thought were the nine greatest Americans. Presently she stopped at a desk and asked, "Haven't you finished your list, Bobby?"

"No'm," replied Bobby, "I can't decide on the shortstop."

———

"Hank," asked Jim, "why doesn't a dollar do as much for people as it once did?"

"Because people don't do as much for a dollar as they once did," replied Hank.

"Hey, isn't he the one I told to stay off his feet over the weekend?"

STATEMENT OF OWNERSHIP

STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946 (Title 39, United States Code, Section 233) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF

The Journal of the American Podiatry Association, published monthly at Boston, Massachusetts, for October 1, 1959.

1. The names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, American Podiatry Association, 3301 16th Street, N. W., Washington 10, D. C.; Editor, A. Rubin, D.S.C., 3301 16th Street, N. W., Washington 10, D. C.

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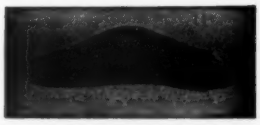

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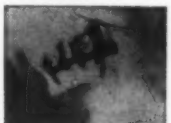

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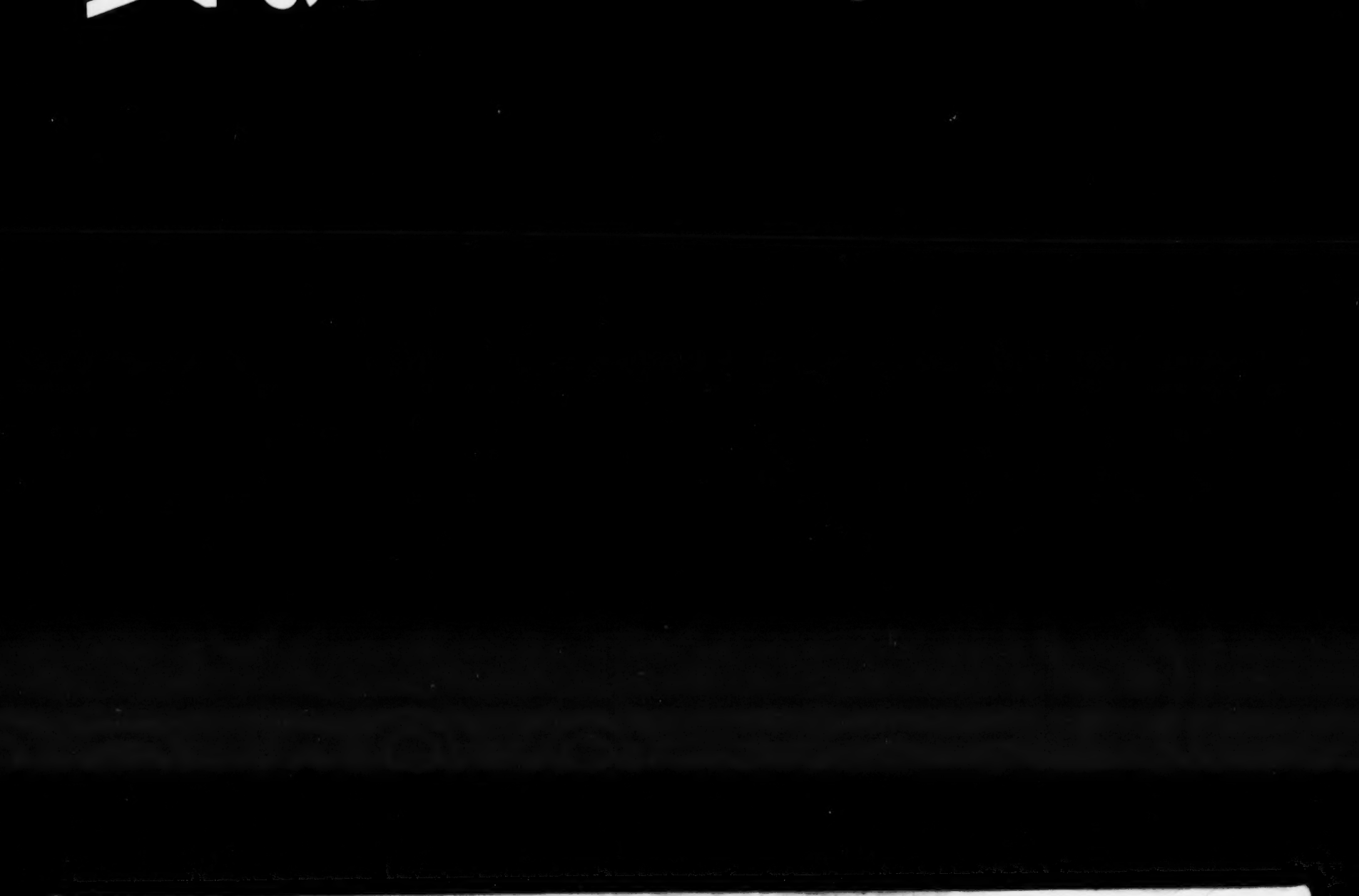
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